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Federal Register

Briefing on How To Use the Federal Register
For information on a briefing in Chicago, IL, see
announcement on the inside cover of this issue.



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WHAT IT IS AND HOW TO USE IT

- FOR:** Any person who uses the Federal Register and Code of Federal Regulations.
- WHO:** The Office of the Federal Register.
- WHAT:** Free public briefings (approximately 3 hours) to present:
1. The regulatory process, with a focus on the Federal Register system and the public's role in the development of regulations.
 2. The relationship between the Federal Register and Code of Federal Regulations.
 3. The important elements of typical Federal Register documents.
 4. An introduction to the finding aids of the FR/CFR system.
- WHY:** To provide the public with access to information necessary to research Federal agency regulations which directly affect them. There will be no discussion of specific agency regulations.

CHICAGO, IL

- WHEN:** June 16; 9:00 a.m.
- WHERE:** Room 328
Ralph H. Metcalfe Federal Building
77 W. Jackson
Chicago, IL
- RESERVATIONS:** Call the Federal Information Center,
1-800-366-2998

Contents

Federal Register

Vol. 57, No. 108

Thursday, June 4, 1992

Agency for Toxic Substances and Disease Registry

NOTICES

Meetings:

- Standardized test battery for immune function disorders for use in environmental health field studies; workshop, 23591

Agricultural Stabilization and Conservation Service

RULES

- Conservation and environmental programs: Wetlands reserve program, 23908

Agriculture Department

See Agricultural Stabilization and Conservation Service

See Animal and Plant Health Inspection Service

See Forest Service

See Soil Conservation Service

NOTICES

- Agency information collection activities under OMB review, 23570

Alcohol, Tobacco and Firearms Bureau

PROPOSED RULES

- Alcohol; viticultural area designations: Spring Mountain, CA, 23559

Animal and Plant Health Inspection Service

PROPOSED RULES

- Veterinarian accreditation, 23540

Antitrust Division

NOTICES

- National cooperative research notifications: Network Management Forum, 23600

Army Department

See Engineers Corps

Children and Families Administration

NOTICES

- Agency information collection activities under OMB review, 23590

Coast Guard

RULES

- Ports and waterways safety: St. Johns River, Jacksonville, FL; safety zone, 23534
- Regattas and marine parades: Norfolk Harborfest 1992, 23533
- Ray Catena Mercedes-Benz Offshore Grand Prix, 23533
- Sodus Bay 4th of July Fireworks, 23534

PROPOSED RULES

- Ports and waterways safety: Rhode Island Sound, RI; safety zone, 23581

Commerce Department

See International Trade Administration

See National Institute of Standards and Technology

See National Oceanic and Atmospheric Administration

Committee for the Implementation of Textile Agreements

NOTICES

- Cotton, wool, and man-made textiles: Indonesia, 23574

Commodity Futures Trading Commission

NOTICES

- Meetings; Sunshine Act, 23615

Defense Department

See Engineers Corps

Defense Nuclear Facilities Safety Board

NOTICES

Recommendations:

- Energy Department's facility representative program at defense nuclear facilities, 23576
- Savannah River Site, SC—HB-Line; operational readiness reviews, 23578

Energy Department

See Federal Energy Regulatory Commission

See Hearings and Appeals Office, Energy Department

RULES

- Natural gas use to displace fuel oil; certification; CFR Part removed, 23523

NOTICES

- Natural gas exportation and importation: Williams Gas Marketing Co., 23581

Engineers Corps

NOTICES

- Regulatory guidance letters, 23574

Environmental Protection Agency

NOTICES

- Agency information collection activities under OMB review, 23586

Meetings:

- Science Advisory Board, 23586
- Superfund; response and remedial actions, proposed settlements, etc.: Baxter/Union Pacific Tie Treating Site, WY, 23587

Executive Office of the President

See Presidential Commission on Assignment of Women in the Armed Forces

See Science and Technology Policy Office

See Trade Representative, Office of United States

Federal Aviation Administration

RULES

- Air carrier certification and operations: Commercial passenger or cargo operations; certification and operating requirements (SFAR No. 38-2), 23922

Airworthiness directives:

- Air Cruisers Co., 23526
- Bell, 23527
- British Aerospace, 23528-23530

Airworthiness standards:

- Special conditions—Bell Helicopter Textron models 212 and 412 helicopters, 23523

PROPOSED RULES

- Airworthiness directives: Boeing, 23549

British Aerospace, 23550
 Fokker, 23552
 McDonnell Douglas, 23553

NOTICES

Grants and cooperative agreements; availability, etc.:
 Airway science program, 23609
 Passenger facility charges; applications, etc.:
 Allentown-Bethlehem-Easton International Airport, PA,
 23609
 Morgantown Municipal Airport, WV, 23611
 University Park Airport, PA, 23610

Federal Communications Commission**PROPOSED RULES**

Radio stations; table of assignments:
 Puerto Rico et al., 23567

NOTICES

Common carrier services:
 International traffic data; reporting requirements, 23587

Federal Election Commission**NOTICES**

Meetings; Sunshine Act, 23615

Federal Emergency Management Agency**NOTICES**

Disaster and emergency areas:
 California, 23588

Federal Energy Regulatory Commission**NOTICES**

Environmental statements; availability, etc.:
 Merced Irrigation District, CA, 23579
Applications, hearings, determinations, etc.:
 CNG Transmission Corp., 23580
 Eastern Shore Natural Gas Co., 23580
 Gas Research Institute, 23580
 Texas Gas Transmission Corp., 23581

Federal Maritime Commission**PROPOSED RULES**

Maritime carriers in domestic offshore and foreign commerce:
 Outdated and unnecessary regulatory provisions elimination, 23566
 Maritime carriers in foreign commerce:
 Anti-rebate certifications; filing requirements, 23563
 Terminal barge operators in Pacific Slope States; tariffs filing; CFR Part removed, 23564

NOTICES

Agreements filed, etc., 23588

Federal Reserve System**NOTICES**

Applications, hearings, determinations, etc.:
 Day, John Horace, 23588
 Story County Bancorporation et al., 23589
 Tomoka Bancorp, Inc., 23589

Food and Drug Administration**PROPOSED RULES**

Food for human consumption:
 Orange juice products; identity standards, 23555

Forest Service**NOTICES**

Appeal exemptions; timber sales:
 Boise National Forest, ID, 23570, 23571

General Accounting Office**NOTICES**

Meetings:
 Federal Accounting Standards Advisory Board, 23589

General Services Administration**NOTICES**

Federal Supply Service orders; electronic price catalog specifications, 23590

Health and Human Services Department

See Agency for Toxic Substances and Disease Registry
See Children and Families Administration
See Food and Drug Administration
See Health Care Financing Administration
See Public Health Service

Health Care Financing Administration**PROPOSED RULES**

Medicare:
 Inpatient hospital prospective payment system and 1993 FY rates, 23618

Health Resources and Services Administration

See Public Health Service

Hearings and Appeals Office, Energy Department**NOTICES**

Cases filed, 23581, 23582
 Decisions and orders, 23584

Housing and Urban Development Department**NOTICES**

Agency information collection activities under OMB review, 23592
 Organization, functions, and authority delegations:
 Home Investment Partnerships (HOME) Program—
 Deputy Assistant Secretary for Grant Programs, 23593
 Regional Administrators et al., 23594

Interior Department

See Land Management Bureau
See Surface Mining Reclamation and Enforcement Office

International Trade Administration**NOTICES**

Applications, hearings, determinations, etc.:
 University of—
 Nebraska-Lincoln et al., 23572
 Washington State University et al., 23573

Interstate Commerce Commission**RULES**

Contracts and exemptions:
 Surface mail transportation; U.S. Postal Service contract, 23538

PROPOSED RULES

Motor carriers:
 Nonoperating carriers; undercharges collection, 23568

NOTICES

Motor and water carriers:
 Finance applications, 23598
 Railroad operation, acquisition, construction, etc.:
 Alabama Great Southern Railroad Co., 23598
 McCloud Railway Co., 23599

Justice Department

See Antitrust Division

See National Institute of Corrections

NOTICES

Pollution control; consent judgments:

Chevron U.S.A., Inc., 23599

Jamestown, ND, et al., 23599

Union Pacific Railroad Co., 23600

Labor Department

See Occupational Safety and Health Administration

Land Management Bureau**NOTICES**

Meetings:

Salem District Advisory Council, 23594

Opening of public lands:

Utah, 23594

Realty actions; sales, leases, etc.:

California, 23595

Utah, 23595, 23596

Resource management plans, etc.:

Caballo Resource Area, NM, 23597

Migrant Education, National Commission

See National Commission on Migrant Education

National Advisory Council on the Public Service**NOTICES**

Meetings, 23602

National Archives and Records Administration**NOTICES**

Agency records schedules; availability, 23601

Nixon Presidential historical materials; opening of materials, 23602

National Commission on Migrant Education**NOTICES**

Meetings, 23603

National Highway Traffic Safety Administration**RULES**

Motor vehicle theft prevention standards:

Insurer reporting requirements; list of companies, 23535

National Institute of Corrections**NOTICES**

Meetings:

Advisory Board, 23600

National Institute of Standards and Technology**NOTICES**

Meetings:

Weights and Measures National Conference, 23573

National Oceanic and Atmospheric Administration**NOTICES**

Meetings:

Mid-Atlantic Fishery Management Council, 23573

Pacific Fishery Management Council, 23574

National Science Foundation**NOTICES**

Meetings:

Networking and Communications Research and Infrastructure Special Emphasis Panel, 23603

Nuclear Regulatory Commission**PROPOSED RULES**

Reactor site criteria:

Nuclear power plants; seismic and geologic siting criteria; Appendix A revision; meeting, 23548

NOTICES

Agency information collection activities under OMB review, 23603

Occupational Safety and Health Administration**NOTICES**

Meetings:

Shipyard Employment Standards Advisory Committee, 23600

Office of United States Trade Representative

See Trade Representative, Office of United States

Postal Rate Commission**NOTICES**

Meetings; Sunshine Act, 23615

Presidential Commission on Assignment of Women in the Armed Forces**NOTICES**

Meetings, 23606

Prospective Payment Assessment Commission**NOTICES**

Meetings, 23606

Public Health Service

See Agency for Toxic Substances and Disease Registry

See Food and Drug Administration

NOTICES

National toxicology program:

Toxicology and carcinogenesis studies—

Chlorinated and chloraminated water, 23591

Ethylene thiourea, 23592

Science and Technology Policy Office**NOTICES**

Meetings:

President's Council of Advisors on Science and Technology, 23604

Securities and Exchange Commission**NOTICES**

Applications, hearings, determinations, etc.:

Mills Value Fund, Inc., 23606

Small Business Administration**NOTICES**

Disaster loan areas:

Virginia, 23607

License surrenders:

Yusa Capital Corp., 23607

Meetings; regional advisory councils:

Connecticut, 23607

Organization, functions, and authority delegations:

Assistant Administrator for Financial Assistance et al., 23607

Applications, hearings, determinations, etc.:

EQUICO Capital Corp., 23608

Soil Conservation Service**NOTICES**

Environmental statements; availability, etc.:

Upper North Bosque River Watershed, TX, 23572

State Department**NOTICES**

Passport travel restrictions, U.S.:
Suriname, 23608

Surface Mining Reclamation and Enforcement Office**NOTICES**

Agency information collection activities under OMB review,
23598

Tennessee Valley Authority**RULES**

Freedom of Information Act; implementation, 23531

Textile Agreements Implementation Committee

See Committee for the Implementation of Textile
Agreements

Toxic Substances and Disease Registry Agency

See Agency for Toxic Substances and Disease Registry

Trade Representative, Office of United States**NOTICES**

Intellectual property rights protection, countries denying:
policies and practices:
Taiwan, 23605

Transportation Department

See Coast Guard

See Federal Aviation Administration

See National Highway Traffic Safety Administration

PROPOSED RULES

Nondiscrimination on basis of handicap in air travel:
Lift boarding devices for small (commuter) aircraft;
workshop, 23555

Treasury Department

See Alcohol, Tobacco and Firearms Bureau

NOTICES

Organization, functions, and authority delegations:
Commissioner of Internal Revenue et al., 23611

Veterans Affairs Department**NOTICES**

Agency information collection activities under OMB review,
23611-23613

Veterans Affairs Medical Center, Washington, DC; child
care development under enhanced-use lease terms,
23614

Separate Parts In This Issue**Part II**

Department of Health and Human Services, Health Care
Financing Administration, 23618

Part III

Department of Agriculture, Agricultural Stabilization and
Conservation Service, 23908

Part IV

Department of Transportation, Federal Aviation
Administration, 23922

Reader Aids

Additional information, including a list of public
laws, telephone numbers, and finding aids, appears
in the Reader Aids section at the end of this issue.

CFR PARTS AFFECTED IN THIS ISSUE

A cumulative list of the parts affected this month can be found in the Reader Aids section at the end of this issue.

7 CFR	
703.....	23908
9 CFR	
Proposed Rules:	
160.....	23540
161.....	23540
162.....	23540
10 CFR	
595.....	23523
Proposed Rules:	
100.....	23548
14 CFR	
21.....	23523
29.....	23523
39 (5 documents).....	23526-
	23530
121.....	23922
125.....	23922
127.....	23922
129.....	23922
135.....	23922
Proposed Rules:	
39 (4 documents).....	23549-
	23553
382.....	23555
18 CFR	
1301.....	23531
21 CFR	
Proposed Rules:	
146.....	23555
27 CFR	
Proposed Rules:	
9.....	23559
33 CFR	
100 (3 documents).....	23533,
	23534
165.....	23534
Proposed Rules:	
165.....	23561
42 CFR	
Proposed Rules:	
412.....	23618
413.....	23618
46 CFR	
Proposed Rules:	
510.....	23563
520.....	23564
550 (2 documents).....	23564,
	23566
580 (3 documents).....	23563,
	23564, 23566
582.....	23563
47 CFR	
Proposed Rules:	
73.....	23567
49 CFR	
544.....	23535
1332.....	23538
Proposed Rules:	
1321.....	23568

Rules and Regulations

Federal Register

Vol. 57, No. 108

Thursday, June 4, 1992

This section of the **FEDERAL REGISTER** contains regulatory documents having general applicability and legal effect, most of which are keyed to and codified in the Code of Federal Regulations, which is published under 50 titles pursuant to 44 U.S.C. 1510. The Code of Federal Regulations is sold by the Superintendent of Documents. Prices of new books are listed in the first **FEDERAL REGISTER** issue of each week.

DEPARTMENT OF ENERGY

Office of Fossil Energy

10 CFR Part 595

Existing Regulations and Programs; Regulatory Review

AGENCY: Office of Fossil Energy, DOE.

ACTION: Final rule.

SUMMARY: The Department of Energy Office of Fossil Energy is eliminating the regulations codified at 10 CFR part 595, entitled "Certification of Use of Natural Gas to Displace Fuel Oil."

EFFECTIVE DATE: June 4, 1992.

FOR FURTHER INFORMATION CONTACT:

Keith N. Frye, U.S. Department of Energy (FE-13), Washington, DC 20585, (301) 903-2644.

SUPPLEMENTARY INFORMATION:

The regulations codified at 10 CFR part 595, entitled "Certification of Use of Natural Gas to Displace Fuel Oil," are being eliminated because the regulations which required the use of the part 595 procedures were themselves eliminated in 1983.

The Federal Energy Regulatory Commission's Order No. 30 Program at 10 CFR part 284, subpart F, authorized the transportation of natural gas directly by end-users to displace fuel oil, but only after the Economic Regulatory Administration of the Department of Energy ("DOE") had issued a certificate of eligible use pursuant to the procedures in 10 CFR part 595.

The Order 30 Program terminated on November 4, 1983, along with DOE's eligible-use certification procedures in 10 CFR part 595 (48 FR 38207, August 23, 1983). The part 595 regulations, however, inadvertently were not removed from

the Code of Federal Regulations at that time.¹

List of Subjects in 10 CFR Part 595

Fossil Energy.

Issued in Washington, DC on May 28, 1992.

James G. Randolph,

Assistant Secretary for Fossil Energy.

For the reasons set forth in the preamble, part 595 of title 10, chapter II, of the Code of Federal Regulations is amended as set forth below:

PART 595—CERTIFICATION OF USE OF NATURAL GAS TO DISPLACE FUEL OIL [REMOVED]

1. Part 595 is removed.

[FR Doc. 92-13109 Filed 6-3-92; 8:45 am]

BILLING CODE 6450-01-M

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Parts 21 and 29

[Docket No. 92-ASW-1; Special Condition 29-ASW-6]

Special Conditions: Bell Helicopter Textron Model 212 and Model 412 Helicopters, Electronic Flight Instrument System

AGENCY: Federal Aviation Administration, DOT.

ACTION: Final special condition; request for comments.

SUMMARY: This special condition is issued for certain Bell Helicopter Textron Models 212 and 412 helicopters modified by Premier Aviation, Inc. These helicopters will have a novel or unusual design feature associated with the Electronic Flight Instrument System (EFIS). The applicable airworthiness regulations do not contain appropriate safety standards for the requirements to protect systems that perform critical functions from the effects of external radio frequency energy sources. This special condition contains additional safety standards that the Administrator considers necessary to ensure that critical functions of systems would be maintained when exposed to high intensity radiated fields (HIRF).

¹ The part 595 regulations were properly removed from the Federal Energy Guidelines. See 2 FEC 25001-25302 (1990).

DATES: Effective June 4, 1992.

Comments for inclusion in the Rules Docket must be received by September 2, 1992.

ADDRESSES: Submit comments in duplicate to the Federal Aviation Administration (FAA), Office of the Assistant Chief Counsel, Attention: Rules Docket No. 92-ASW-1, Fort Worth, Texas 76193-0007, or deliver in duplicate to the Office of the Assistant Chief Counsel, Building 3B, room 158, 4400 Blue Mound Road, Fort Worth, Texas.

All comments must be marked Docket No. 92-ASW-1. Comments may be inspected in the Office of the Assistant Chief Counsel, at the address specified above, between 8 a.m. and 4 p.m., weekdays except Federal holidays.

FOR FURTHER INFORMATION CONTACT:

Mr. Carroll Wright, FAA, Rotorcraft Standards Staff, Regulations Group, Fort Worth, Texas 76193-0111; telephone (817) 624-5120.

SUPPLEMENTARY INFORMATION:

Comments Invited

Although this action is in the form of a final special condition and, thus, was not preceded by notice and an opportunity for public comment, comments are invited on this rule.

Interested persons are invited to submit such written data, views, or arguments as they may desire. Communications should identify the regulatory docket and special condition number and be submitted in duplicate to the address specified under the caption.

"ADDRESSES." All communications received on or before the closing date for comments will be considered, and this special condition may be amended in light of comments received. All comments received will be available, both before and after the closing date for comments, in the Rules Docket for examination by interested persons. A report that summarizes each FAA-public contact concerned with the substance of this special condition will be filed in the Rules Docket. Commenters wishing the FAA to acknowledge receipt of their comments submitted in response to this special condition must submit a self-addressed, stamped postcard on which the following statement is made:

"Comments to Docket No. 92-ASW-1." The postcard will be date/time stamped and returned to the commenter.

Background

On April 26, 1991, Premier Aviation, Inc., 2617 Aviation Parkway, Grand Prairie, Texas, applied for a supplemental type certificate (STC) to install a Bendix/King EFIS/50 Electronic Flight Instrument System in the Bell Helicopter Textron Models 212 and 412 helicopters. The Bell Helicopter Textron Models 212 and 412 are currently approved under Type Certificate No. H4SW. The Model 212 is a 14-passenger, two-engine, 11,200-pound transport category helicopter; and Model 412 is a 14-passenger, two-engine, 11,900-pound transport category helicopter.

Type Certification Basis

The certification basis established for the Model 212 includes: FAR part 29 dated February 1, 1965, Amendments 29-1 and 29-2, and FAR 29.473, 29.501, 29.771, 29.903(c), 29.1323, and 29.1505(b) of Amendment 29.3; Special Conditions 29-12-SW-1; and Ditching in accordance with FAR 25.801 including 29.1411 and 29.1415.

The certification basis established for the Model 412 includes: FAR part 29 dated February 1, 1965, Amendments 29-1 and 29-2, and portions of Amendment 29-3, specifically, 29.473, 29.501, 29.633, 29.771, 29.903(c), 29.1323, and 29.1505(b); Special Conditions 29-12-SW-1, Amendment 1; Exemption No. 3100 against FAR 29.1323(c); Category A engine isolation requirements; and Ditching in accordance with FAR 25.801 including FAR 29.1411 and 29.1415. Bell Helicopter Textron has elected to comply with portions of Amendments 29-4 through 29-30, specifically 29.151, 29.161, 29.610, 29.672, 29.1301, 29.1303, 29.1309, 29.1321, 29.1329, 29.1331, 29.1333, 29.1335, 29.1351, 29.1353, 29.1431, and Appendix B.

Special conditions may be issued and amended, as necessary, as a part of the type certification basis if the Administrator finds that the airworthiness standards designated in accordance with § 21.101(b)(2) do not contain adequate or appropriate safety standards because of novel or unusual design features of an aircraft or installation. Special conditions, as appropriate, are issued in accordance with § 11.49 and will become a part of the type certification basis, as provided by § 21.101(b)(2).

Discussion

The Bell Helicopter Textron Models 212 and 412 helicopters, at the time of application, were identified as incorporating one and possibly more electrical/electronic systems that will be performing functions critical to the

continued safe flight and landing of the helicopter. The Electronic Flight Instrument System performs the attitude display function. The display of attitude, altitude, and airspeed to the pilot is critical to the continued safe flight and landing of the helicopter for instrument flight rules (IFR) operations in instrument meteorological conditions. When the design is finalized, Premier Aviation, Inc., will provide the FAA with a preliminary hazard analysis that will identify any other critical functions performed by electrical/electronic systems.

Recent advances in technology have given rise to the application in aircraft designs of advanced electrical and electronic systems that perform functions required for continued safe flight and landing. These advanced systems are responsive to the transient effects of induced electrical current and voltage caused by the high intensity radiated fields (HIRF) incident on the external surface of the helicopter. These induced transient currents and voltages can degrade the performance of the electrical/electronic systems by damaging the components or by upsetting the system's functions.

Furthermore, the electromagnetic environment has undergone a transformation not envisioned by the current application of the § 29.1309(a) requirement. Higher energy levels radiate from operational transmitters that are currently used for radar, radio, and television. Also, the number of transmitters has increased significantly.

Existing aircraft certification requirements are inappropriate in view of these technological advances. In addition, the FAA has received reports of some significant safety incidents and accidents involving military aircraft equipped with advanced electronic systems when they were exposed to electromagnetic radiation.

The combined effects of the technological advances in helicopter design and the changing environment have resulted in an increased level of vulnerability of the electrical/electronic systems required for the continued safe flight and landing of the helicopter. Effective measures to protect these helicopters against the adverse effects of exposure to HIRF must be provided by the design and installation of these systems. The primary factors that have contributed to this increased concern are: (1) The increasing use of sensitive electronics that perform critical functions; (2) the reduced electromagnetic shielding afforded helicopter systems by advanced technology airframe materials; (3) the adverse service experience of military

aircraft using these technologies; and (4) the increase in the number and power of radio frequency emitters and the expected increase in the number of these emitters in the future.

The FAA has recognized the need for aircraft certification standards to keep pace with the developments in technology and environment and, in 1986, initiated a high priority program to: (1) Determine and define the electromagnetic energy levels; (2) develop and describe guidance material for design, test, and analysis; and (3) prescribe and promulgate regulatory standards. The FAA participated with industry and airworthiness authorities of other countries to develop internationally recognized standards for certification.

The FAA and airworthiness authorities of other countries have established a level of HIRF environment that a helicopter could be exposed to during IFR operations.

While the HIRF requirements are being finalized, the FAA is adopting special conditions for the certification of aircraft that employ electrical/electronic systems performing critical functions. The accepted maximum energy levels in which civilian helicopter system installations must be capable of operating safely are based on surveys and analysis of existing radio frequency emitters. This special condition requires that the helicopter's electrical/electronic systems and associated wiring harnesses be protected from these energy levels. These external threat levels are believed to represent the worst-case exposure for a helicopter operating under IFR.

The defined HIRF environment specified in this special condition is based on many critical assumptions; among these is that, with the exception of takeoff and landing at an airport, the aircraft would be not less than 500 feet above ground level (AGL). Helicopters operating under visual flight rules (VFR) routinely operate at less than 500 feet AGL and perform takeoffs and landings at locations other than controlled airports. Therefore, it would be expected that the HIRF environment experienced by a helicopter operating VFR may exceed the given environment by twice or more.

This special condition would require qualification of electrical/electronic systems that perform critical functions, as installed in aircraft, to either a defined HIRF environment or a fixed value using laboratory tests.

The applicant may demonstrate that the operation and the operational capability of the installed electrical/

electronic systems that perform critical functions are not adversely affected when the aircraft is exposed to the HIRF environment. The FAA has determined that the environment defined in Table I is acceptable for critical functions in helicopters operating not less than 500 feet AGL. For critical functions in helicopters operating at altitudes less than 500 feet AGL, additional considerations must be given.

The applicant may demonstrate by a laboratory test that the electrical/electronic systems that perform critical functions withstand a peak electromagnetic field strength in a frequency range of 10 KHz to 18 GHz. If a laboratory test is used to show compliance with the HIRF requirements, no credit would be given for signal attenuation due to installation. A level of 100 v/m and further considerations, such as an alternate technology backup that is immune to HIRF, are appropriate at this time for critical functions during IFR operations. A level of 200 v/m and further considerations, such as an alternate technology backup that is immune to HIRF are more appropriate for critical functions during VFR operations.

For helicopters, the primary electronic flight displays are critical for IFR operations and a full authority digital engine control (FADEC) is an example of a critical functioning system for all operations (both IFR and VFR).

A preliminary hazard analysis must be performed by the applicant for approval by the FAA to identify electrical/electronic systems that perform critical functions. The term "critical" means those functions whose failure would contribute to or cause a failure condition that would prevent the continued safe flight and landing of the helicopter. The systems identified by the hazard analysis that perform critical functions are the ones that are required to have HIRF protection.

A system may perform both critical and noncritical functions. Primary electronic flight display systems and their associated components perform critical functions such as attitude, altitude, and airspeed indication. The HIRF requirements would only apply to the critical functions.

Compliance with HIRF requirements will be demonstrated by tests, analysis, models, similarity with existing systems, or a combination of these methods. Service experience alone will not be acceptable since such experience in normal flight operations may not include an exposure to the HIRF environmental condition. Reliance on a system with similar design features for redundancy

as a means of protection against the effects of external HIRF is generally insufficient since all elements of a redundant system are likely to be concurrently exposed to the fields.

The modulation should be selected for the signal most likely to disrupt the operation of the system under test, based on its design characteristics. For example, flight control systems may be susceptible to 3 Hz square wave modulation while the video signals for electronic display systems may be susceptible to 400 Hz sinusoidal modulation. If the worst-case modulation is unknown or cannot be determined, default modulations may be used. Suggested default values are a 1 KHz sine wave with 80 percent depth of modulation in the frequency range from 10 KHz to 400 MHz, and 1 KHz square wave with greater than 90 percent depth of modulation from 400 MHz to 18 GHz. For frequencies where the unmodulated signal would cause deviations from normal operation, several different modulating signals with various waveforms and frequencies should be applied.

Acceptable system performance would be attained by demonstrating that the critical aspects of the system under consideration continue to perform its intended function during and after exposure to required electromagnetic fields. Deviations from system specification may be acceptable but need to be independently assessed by the FAA for each application.

TABLE 1. FIELD STRENGTH VOLTS/METER

Frequency	Peak	Average
10-500 KHz.....	60	60
500-2000.....	80	80
2-30 MHz.....	200	200
30-100.....	33	33
100-200.....	150	33
200-400.....	56	33
400-1000.....	4020	935
1-2 GHz.....	7850	1750
2-4.....	6000	1150
4-6.....	6800	310
6-8.....	3600	666
8-12.....	5100	1270
12-18.....	3500	551
18-40.....	2400	750

Conclusion

This action will affect only certain unusual or novel design features on one series of helicopters. It is not a rule of general applicability and will affect only the manufacturer who applied to the FAA for approval of these features on the affected helicopters.

The substance of this special condition has been subjected to the

notice and comment procedure in several prior special conditions. This special condition has been derived without substantive change from those previously issued. Therefore, it is unlikely that prior public comment would have resulted in a significant change in the substance of this special condition. For this reason, and because a delay would significantly adversely affect the certification of these helicopters, which is imminent, the FAA has determined that prior public notice and comment are unnecessary and impracticable, and good cause exists for adopting this special condition immediately. Therefore, this special condition is being made effective upon issuance. However, the FAA is requesting comments to allow interested persons to submit views that may not have been submitted in response to the similar special conditions previously issued.

List of Subjects in 14 CFR Parts 21 and 29

Aircraft, Air transportation, Aviation safety, Rotorcraft, Safety.

The authority citation for this special condition is as follows:

Authority: 49 U.S.C. 1344, 1348(c), 1352, 1354(a), 1355, 1421 through 1431, 1502, 1651(b)(2); 42 U.S.C. 1857f-10, 4321 et seq.; E.O. 11541; 49 U.S.C. 106(g) (Rev. Pub. L. 97-449, January 12, 1983).

The Final Special Condition

Accordingly, pursuant to the authority delegated to me by the Administrator, the following special condition is issued as part of the supplemental type certification bases for the Bell Helicopter Textron Model 212 and Model 412 helicopters.

Protection for Electrical/Electronic Systems From High Intensity Radiated Fields

Each system that performs critical functions must be designed and installed to ensure that the operation and operational capabilities of these critical functions are not adversely affected when the helicopter is exposed to high intensity radiated fields external to the helicopter.

Issued in Fort Worth, Texas, on May 19, 1992.

Henry A. Armstrong,

Acting Manager, Rotorcraft Directorate, Aircraft Certification Service.

[FR Doc. 92-13069 Filed 6-3-92; 8:45 am]

BILLING CODE 4910-13-M

14 CFR Part 39

[Docket No. 90-ANE-26; Amendment 39-8240, AD 92-10-06]

Airworthiness Directives; Air Cruisers Co., TSO-C69, Evacuation Slides System

AGENCY: Federal Aviation Administration, DOT.

ACTION: Final rule.

SUMMARY: This amendment adopts a new airworthiness directive (AD) applicable to Air Cruisers Co., TSO-C69, Evacuation Slides System, Part Numbers (P/N) D31021-101 and -103. This action requires modification and inspection of slides identified by certain serial numbers. This amendment is prompted by two reports of slides deploying improperly. This condition, if not corrected, could result in improper inflation of the slides, which could hamper the emergency evacuation of an aircraft.

DATES: Effective July 6, 1992.

The incorporation by reference of certain publications listed in the regulations is approved by the Director of the Federal Register as of July 6, 1992.

ADDRESSES: The service information referenced in this AD may be obtained from Air Cruisers Co., P.O. Box 180, Belmar, NJ 07719-0180. This information may be examined at the Federal Aviation Administration (FAA), New England Region, Office of the Assistant Chief Counsel, 12 New England Executive Park, Burlington, Massachusetts, or at the Office of the Federal Register, 1100 L Street NW., room 8401, Washington, DC.

FOR FURTHER INFORMATION CONTACT: Mr. C. Kallis, Aerospace Engineer, New York Aircraft Certification Office, Systems and Equipment Branch, ANE-173, Engine & Propeller Directorate, Aircraft Certification Service, FAA, 181 South Franklin Avenue, room 202, Valley Stream, New York 11581-1145; telephone (516) 791-6427.

SUPPLEMENTARY INFORMATION: A proposal to amend part 39 of the Federal Aviation Regulations to include a new airworthiness directive (AD), that is applicable to Air Cruisers Evacuation Slides, Part Numbers (P/N) D31021-101 and -103, was published in the *Federal Register* on January 28, 1991 (56 FR 3051). That action proposed to require modifications and inspections of slides identified by certain serial numbers in accordance with Air Cruisers Co., Service Bulletin No. 001-25-8, Revision 4, dated May 24, 1990.

Interested persons have been afforded an opportunity to participate in the

making of this amendment. Two comments were received.

One commenter recommends that the slides be modified at the earliest opportunity to ensure that a high level of reliability exists in these systems. The AD as proposed requires compliance within nine months after the effective date of the AD. No alternative compliance period was proposed, and the FAA finds that the proposed compliance time provides an acceptable level of safety. Therefore, the proposed compliance time has not been altered.

The other commenter expressed no objection to adoption of the proposed rule.

Paragraph (a) of the AD has been reworded for clarity by including the affected part numbers and serial numbers.

The economic analysis has been revised to increase the specified hourly labor rate from \$40 per manhour, as was discussed in the NPRM, to \$55 per manhour.

After careful review of the available data, including the comments noted above, the FAA has determined that air safety and the public interest require the adoption of the rule as proposed, with the changes described.

There are approximately 222 emergency evacuation slides of the affected design in the worldwide fleet. It is estimated that 120 slides on aircraft of U.S. registry will be affected by this AD, that it will take approximately 8 manhours per slide to accomplish the required actions, and that the average labor cost will be \$55 per manhour. The cost of required parts is estimated to be \$680 per slide. Based on these figures, the total cost impact of the AD on U.S. operators is estimated to be \$135,000.

The regulations adopted herein will not have substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government. Therefore, in accordance with Executive Order 12612, it is determined that this final rule does not have sufficient federalism implications to warrant the preparation of a Federalism Assessment.

For the reasons discussed above, I certify that this action (1) is not a "major rule" under Executive Order 12291; (2) is not a "significant rule" under DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and (3) will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act. A final evaluation has been prepared for this action and it is contained in the

Rules Docket. A copy of it may be obtained from the Rules Docket at the location provided under the caption **ADDRESSES**.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Incorporation by reference, Safety.

Adoption of the Amendment

Accordingly, pursuant to the authority delegated to me by the Administrator, the Federal Aviation Administration (FAA) amends 14 CFR part 39 of the Federal Aviation Regulations (FAR) as follows:

PART 39—AIRWORTHINESS DIRECTIVES

1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. App. 1354(a), 1421 and 1423; 49 U.S.C. 106(g); and 14 CFR 11.89.

§ 39.13 [Amended]

2. Section 39.13 is amended by adding the following new airworthiness directive:

AD 92-10-06 Air Cruisers Company:
Amendment No. 39-8240 Docket No. 90-ANE-26

Applicability: Air Cruisers Co. TSO-C69 Emergency Evacuation Slide System, Part Numbers (P/N) D31021-101 and -103, Serial Numbers 1 through 222, installed on but not limited to Airbus Industries Models A300 B2-1C, A300 B4-2C, A300 BA-200 and A300 B4-600 series aircraft.

Compliance: Required within 9 months after the effective date of this AD, unless previously accomplished.

To prevent improper inflation of the slides, which could hamper the emergency evacuation of an aircraft, accomplish the following:

(a) Modify and reidentify Air Cruisers Co. Evacuation Slide System, P/N D31021-101 and -103, serial numbers 1 through 222, in accordance with Air Cruisers Co. Service Bulletin (SB) 001-25-8, Revision 4, dated May 24, 1990, Paragraph 2, Accomplishment instructions.

(b) Special flight permits may be issued in accordance with FAR 21.197 and 21.199 to operate the airplane to a location where the requirements of this AD can be accomplished.

(c) An alternative method of compliance or adjustment of the compliance time that provides an acceptable level of safety, may be used if approved by the Manager, New York Aircraft Certification Office, Engine and Propeller Directorate, Aircraft Certification Service, FAA, 181 South Franklin Avenue, Valley Stream, New York 11581-1145. The request should be forwarded through an FAA Principal Maintenance Inspector, who may add comments and then send it to the Manager, New York Aircraft Certification Office.

Note: Information concerning the existence of approved alternative methods of compliance with this airworthiness directive, if any, may be obtained from the New York Aircraft Certification Office.

(d) The modifications and inspections required by this AD shall be accomplished in accordance with the following Air Cruisers Co. Service Bulletin:

Document No.	Page	Issue/Revision	Date
S.B.001-25-8.	1, 3, 4, 5, 8, 9, 11, 14, 16, 21, and 22.	Rev. No. 4... Rev. No. 3...	May 24, 1990. April 30, 1990.
	2, 6, 7, 10, 12, 13, 15, 17, 18, 19, 20, 23, 24, 25, and 26.		

Total Pages: 26.

The incorporation by reference was approved by the Director of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. Copies may be obtained from Air Cruisers Co., P.O. Box 180 Belmar, NJ 07719-0180. Copies may be reviewed at the FAA, New England Region, Office of the Assistant Chief Counsel, 12 New England Executive Park, room 311, Burlington, Massachusetts, or at the Office of the Federal Register, 1100 L Street, NW., room 8401, Washington, DC.

(e) This amendment becomes effective July 6, 1992.

Issued in Burlington, Massachusetts, on April 17, 1992.

Michael H. Borfritz,

Acting Manager, Engine and Propeller Directorate, Aircraft Certification Service.

[FR Doc. 92-13041 Filed 6-3-92; 8:45 am]

BILLING CODE 4910-13-M

14 CFR Part 39

[Docket No. 91-ASW-33; Amendment 39-8232; AD 92-09-07]

Airworthiness Directives; Bell Helicopter Textron, Inc., Model 206A and 206B Helicopters

AGENCY: Federal Aviation Administration, DOT.

ACTION: Final rule; request for comments.

SUMMARY: This amendment adopts a new airworthiness directive (AD) that is applicable to Bell Model 206A and 206B helicopters. This action requires an inspection for cracks and modification of the vertical fin supports. In addition, an inspection for gaps between the vertical fin supports and fin mounted inserts is required. This amendment is prompted by a manufacturer's report that installation of an external doubler on the vertical fin may require spacers between the fin and the tailboom to preclude unacceptable loads on certain

fin supports. The actions specified in this AD are intended to prevent fatigue failure of the vertical fin supports that could result in loss of the vertical fin and loss of control of the helicopter.

DATES: Effective June 29, 1992.

The incorporation by reference of certain publications listed in the regulations is approved by the Director of the Federal Register as of June 29, 1992.

Comments for inclusion in the Rules Docket must be received by July 20, 1992.

ADDRESSES: The applicable Alert Service Bulletin may be obtained from Bell Helicopter Textron, Inc., P.O. Box 482, Fort Worth, TX 76101. This information may be examined at the FAA, Office of the Assistant Chief Counsel, Rules Docket, 4400 Blue Mound Road, room 158, Building 3B, Fort Worth, Texas.

Submit comments in triplicate to the Federal Aviation Administration (FAA), Office of the Assistant Chief Counsel, Attention: Rules Docket No. 91-ASW-33, 4400 Blue Mound Road, Fort Worth, Texas 76193-0007.

FOR FURTHER INFORMATION CONTACT: Mr. Richard Monschke, FAA, Rotorcraft Certification Office, ASW-170, Fort Worth, Texas 76193-0170, telephone (817) 624-5277.

SUPPLEMENTARY INFORMATION: Bell Helicopter Service Letter No. 206-203, dated December 18, 1972, modified Bell Model 206A and 206B helicopters by adding a doubler, part number (P/N) 206-020-113-109, to the vertical fin, P/N 206-020-113-5, -7, -9, and 107. This doubler provided additional strength to the inboard side of the vertical fin and provided an acceptable repair for cracked fins. Bell Helicopter Alert Service Bulletin No. 206-01-73-5, dated June 27, 1973, provided for the inspection and replacement of cracked vertical fin supports, P/N 206-031-417-003, -007, 206-031-418-001, and -005. Airworthiness Directives No. 73-12-01 and 73-21-03 mandated compliance with these two service letters or bulletins.

Recently the FAA received a report of cracked vertical fin supports on a Bell 206B helicopter. Further engineering analysis and investigation has determined that if a gap exists between the fin mounted inserts and the vertical fin supports, unacceptable loads could occur on the supports. This condition, if not corrected, could result in fatigue failure of the vertical fin supports, loss of the vertical fin, and subsequent loss of control of the helicopter.

Since this condition described is likely to exist or develop on other helicopters of the same type design, this AD is being

issued to prevent fatigue failure of the vertical fin supports. This AD requires an inspection for cracks in the vertical fin supports and a modification to affected fin assemblies to reduce the fatigue exposure of the vertical fin supports.

Since a situation exists that requires the immediate adoption of this regulation, it is found that notice and opportunity for prior public comment hereon are impracticable, and that good cause exists for making this amendment effective in less than 30 days.

Comments Invited

Although this action is in the form of a final rule that involves requirements affecting flight safety and, thus, was not preceded by notice and an opportunity for public comment, comments are invited on this rule. Interested persons are invited to submit such written data, views, or arguments as they may desire. Communications should identify the Rules Docket number and be submitted in triplicate to the address specified under the caption **ADDRESSES**. All communications received on or before the closing date for comments will be considered, and this rule may be changed in light of the comments received. Factual information that supports the commenter's ideas and suggestions is extremely helpful in evaluating the effectiveness of the AD action and determining whether additional rulemaking action would be needed.

Comments are specifically invited on the overall regulatory, economic, environmental, and energy aspects of the rule that might suggest a need to modify the rule. All comments submitted will be available, both before and after the closing date for comments, in the Rules Docket for examination by interested persons. A report summarizing each FAA-public contact concerned with the substance of the AD will be filed in the Rules Docket.

Commenters wishing the FAA to acknowledge receipt of their comments submitted in response to this rule must submit a self-addressed, stamped postcard on which the following statement is made: "Comments to Docket Number 91-ASW-33." The postcard will be date stamped and returned to the commenter.

The regulations adopted herein will not have substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government. Therefore, in accordance with Executive Order 12612, it is determined that this final rule does not

have sufficient federalism implications to warrant the preparation of a Federalism Assessment.

The FAA has determined that this regulation is an emergency regulation and that it is not considered to be major under Executive Order 12291. It is impracticable for the agency to follow the procedures of Executive Order 12291 with respect to this rule since the rule must be issued immediately to correct an unsafe condition in aircraft. It has been determined further that this action involves an emergency regulation under DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979). If it is determined that this emergency regulation otherwise would be significant under DOT Regulatory Policies and Procedures, a final regulatory evaluation will be prepared and placed in the Rules Docket. A copy of it, if filed, may be obtained from the Rules Docket at the location provided under the caption **ADDRESSES**.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Incorporation by reference, and Safety.

Adoption of the Amendment

Accordingly, pursuant to the authority delegated to me by the Administrator, the Federal Aviation Administration amends 14 CFR part 39 of the Federal Aviation Regulations as follows:

PART 39—AIRWORTHINESS DIRECTIVES

1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 1354(a), 1421 and 1423; 49 U.S.C. 106(g); and 14 CFR 11.89.

§ 39.13 [Amended]

2. Section 39.13 is amended by adding the following new airworthiness directive:

AD 22-09-07 Bell Helicopter Textron, Inc. (BHTI): Amendment 39-8232 Docket No. 91-ASW-33.

Applicability: All Bell Helicopter Textron, Inc., Model 206A and 206B helicopters, serial numbers (S/N) 4 through 1163, certificated in any category, equipped with a vertical fin assembly that has an external doubler, part number (P/N) 206-020-113-109, installed on the lefthand side adjacent to the supports.

Compliance: Required within 30 days or 100 hours' time in service, whichever comes first, after the effective date of this AD, unless previously accomplished.

To prevent failure of the vertical fin supports, which could result in loss of the vertical fin and loss of control of the helicopter, accomplish the following:

(a) Inspect for cracks and modify the vertical fin supports in accordance with part I

of Bell Helicopter Alert Service Bulletin No. 206-91-60, dated June 28, 1991.

(b) Prior to reinstalling the fin assembly, inspect for any gaps between the tailboom and the fin mounted inserts. If any gaps are found, comply with part II of Bell Helicopter Alert Service Bulletin No. 206-91-60, dated June 28, 1991. If gaps are not found, reassemble the aircraft in accordance with the manufacturer's maintenance manual.

(c) An alternative method of compliance or adjustment of the compliance time, which provides an acceptable level of safety, may be used when approved by the Manager, Rotorcraft Certification Office, ASW-170, 4400 Blue Mound Road, Fort Worth, Texas, 76193-0170. The request shall be forwarded through an FAA Principal Maintenance Inspector, who may concur or comment and then send it to the Manager, Rotorcraft Certification Office.

(d) Special flight permits may be issued in accordance with FAR 21.197 and 21.199 to operate the helicopter to a location where the requirements of this AD can be accomplished.

(e) The inspections and modifications to the vertical fin assembly and supports, and the inspection for gaps shall be done in accordance with Bell Helicopter Alert Service Bulletin No. 206-91-60, parts I and II, dated June 28, 1991. This incorporation by reference was approved by the Director of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. Copies may be obtained from Bell Helicopter Textron, Inc., P.O. Box 482, Fort Worth, Texas 76101. Copies may be inspected at the FAA, Office of the Assistant Chief Counsel, FAA, 4400 Blue Mound Road, Bldg. 3B, room 158, Fort Worth, Texas, or at the Office of the Federal Register, 1100 L Street NW., room 8401, Washington, DC.

(f) This amendment becomes effective June 29, 1992.

Issued in Fort Worth, Texas, on April 6, 1992.

Henry A. Armstrong,

Acting Manager, Rotorcraft Directorate, Aircraft Certification Service.

[FR Doc. 92-13040 Filed 6-3-92; 8:45 am]

BILLING CODE 4910-13-M

14 CFR Part 39

[Docket No. 92-NM-06-AD; Amendment 39-8256; AD 92-11-06]

Airworthiness Directives; British Aerospace Model BAe 146-100A, 200A, and 300A Series Airplanes

AGENCY: Federal Aviation Administration, DOT.

ACTION: Final rule.

SUMMARY: This amendment adopts a new airworthiness directive (AD), applicable to British Aerospace Model BAe 146-100A, 200A, and 300A series airplanes, that requires installation of shorter hoses at certain locations in the pitot-static system on affected airplanes. This amendment is prompted by recent

reports of low spots in pitot-static system hoses that could result in water being trapped and causing the pitot-static system to malfunction. The actions specified by this AD are intended to eliminate the low spots and prevent the generation of incorrect air speed and altitude information.

DATES: Effective July 9, 1992.

The incorporation by reference of certain publications listed in the regulations is approved by the Director of the Federal Register as of July 9, 1992.

ADDRESSES: The service information referenced in this AD may be obtained from British Aerospace, PLC, Librarian for Service Bulletins, P.O. Box 17414, Dulles International Airport, Washington DC 20041-0414. This information may be examined at the Federal Aviation Administration (FAA), Transport Airplane Directorate, Rules Docket, 1601 Lind Avenue SW., Renton, Washington; or at the Office of the Federal Register, 1100 L Street NW., room 8401, Washington, DC.

FOR FURTHER INFORMATION CONTACT: William Schroeder, Standardization Branch, ANM-113, FAA, Transport Airplane Directorate, 1601 Lind Avenue SW., Renton, Washington 98055-4056; telephone (206) 227-2113; fax (206) 227-1320.

SUPPLEMENTARY INFORMATION: A proposal to amend part 39 of the Federal Aviation Regulations to include an airworthiness directive (AD) that is applicable to British Aerospace Model BAe 146-100A, 200A, and 300A series airplanes was published in the Federal Register on February 12, 1992 (57 FR 5085). That action proposed to require installation of shorter hoses at certain locations in the pitot-static system on affected airplanes.

Interested persons have been afforded an opportunity to participate in the making of this amendment. Due consideration has been given to a single comment received.

The commenter supports the proposed rule.

After careful review of the available data, including the comment noted above, the FAA has determined that air safety and the public interest require the adoption of the rule as proposed.

The FAA estimates that 18 airplanes of U.S. registry will be affected by this AD, that it will take approximately 9 work hours per airplane to accomplish the required actions, and that the average labor rate is \$55 per work hour. Required parts will cost approximately \$494 per airplane. Based on these figures, the total cost impact of the AD

on U.S. operators is estimated to be \$17,802.

The regulations adopted herein will not have substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government. Therefore, in accordance with Executive Order 12612, it is determined that this final rule does not have sufficient federalism implications to warrant the preparation of a Federalism Assessment.

For the reasons discussed above, I certify that this action (1) is not a "major rule" under Executive Order 12291; (2) is not a "significant rule" under DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and (3) will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act. A final evaluation has been prepared for this action and it is contained in the Rules Docket. A copy of it may be obtained from the Rules Docket at the location provided under the caption "ADDRESSES."

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Incorporation by reference, Safety.

Adoption of the Amendment

Accordingly, pursuant to the authority delegated to me by the Administrator, the Federal Aviation Administration amends 14 CFR part 39 of the Federal Aviation Regulations as follows:

PART 39—AIRWORTHINESS DIRECTIVES

1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 1354(a), 1421 and 1423; 49 U.S.C. 106(g); and 14 CFR 11.89.

§ 39.13 [Amended]

2. Section 39.13 is amended by adding the following new airworthiness directive:

92-11-06. British Aerospace: Amendment 39-8256. Docket 92-NM-06-AD.

Applicability: British Aerospace Model BAe 146-100A, 200A, and 300A series airplanes, certificated in any category.

Compliance: Required as indicated, unless accomplished previously.

To prevent the generation of incorrect air speed and altitude information, accomplish the following:

(a) For British Aerospace Model BAe 146-200A series airplanes with Serial Numbers E2164 and subsequent; and Model BAe 146-300A series airplanes with Serial Numbers E3118, E3163, and subsequent: Within 30 days

after the effective date of this AD, accomplish the actions specified in paragraphs (a)(1), (a)(2), and (a)(3) of this AD, in accordance with instructions in British Aerospace Service Bulletin SB.34-128-00950J, dated March 22, 1991:

(1) Replace existing pitot-static system hoses at specified location with shorter hoses.

(2) Check the clamp block bolts installation. If any discrepancy is detected, correct it prior to further flight.

(3) Conduct a leak test of the pitot-static system. If any discrepancy is detected, correct it prior to further flight.

(b) For British Aerospace Model BAe 146-100A, 200A, and 300A series airplanes equipped with a True Airspeed Computer No. 1 in accordance with modification HCM40159B or HCM40297G, along with a Mode "S" Transponder in accordance with modification HCM30118B or HCM40277A: Within 90 days after the effective date of this AD, accomplish the actions specified in paragraphs (b)(1) and (b)(2) of this AD, in accordance with instructions in British Aerospace Service Bulletin SB.34-131-46041A, dated June 24, 1991:

(1) Replace existing pitot-static system hoses at specified locations with shorter hoses.

(2) Conduct and leak test of the pitot-static system. If any discrepancy is detected, correct it prior to further flight.

(c) For British Aerospace Model BAe 146-100A, 200A, and 300A series airplanes equipped with a True Airspeed Computer No. 2 in accordance with modification HCM40160C or HCM40298G, along with a Mode "S" Transponder in accordance with modification HCM30118B or HCM40277A: Within 90 days after the effective date of this AD, accomplish the actions specified in paragraphs (c)(1) and (c)(2) of this AD, in accordance with instructions in British Aerospace Service Bulletin SB.34-132-46042A, dated June 24, 1991:

(1) Replace existing pitot-static system hoses at specified locations with shorter hoses.

(2) Conduct a leak test of the pitot-static system. If any discrepancy is detected, correct it prior to further flight.

(d) An alternative method of compliance or adjustment of the compliance time, which provides an acceptable level of safety, may be used when approved by the Manager, Standardization Branch, ANM-113, FAA, Transport Airplane Directorate. The request shall be forwarded through an FAA Principal Maintenance Inspector, who may concur or comment and then send it to the Manager, Standardization Branch, ANM-113.

(e) Special flight permits may be issued in accordance with FAR 21.197 and 21.199 to operate the airplane to a location where the requirements of this AD can be accomplished.

(f) The inspections and modifications shall be done in accordance with British Aerospace Service Bulletin SB.34-128-00950J, dated March 22, 1991; British Aerospace Service Bulletin SB.34-131-46041A, dated June 24, 1991; or British Aerospace Service Bulletin SB.34-132-46042A, dated June 24, 1991; as applicable. This incorporation by

reference was approved by the Director of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. Copies may be obtained from British Aerospace, PLC. Librarian for Service Bulletins, P.O. Box 17414, Dulles International Airport, Washington DC 20041-0414. Copies may be inspected at the FAA, Transport Airplane Directorate, 1601 Lind Avenue SW., Renton, Washington; or at the Office of the Federal Register, 1100 L Street NW., room 8401, Washington, DC.

(g) This amendment becomes effective on July 9, 1992.

Issued in Renton, Washington, on April 29, 1992.

N. B. Martenson,

Acting Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. 92-13043 Filed 6-3-92; 8:45 am]

BILLING CODE 4910-13-M

14 CFR Part 39

[Docket No. 91-NM-280-AD; Amendment 39-8253; AD 92-11-03]

Airworthiness Directives; British Aerospace Model DH/BH/HS 125 Series Airplanes, Excluding Model 125-600A, -700A, -800A, and -1000A Series Airplanes

AGENCY: Federal Aviation Administration, DOT.

ACTION: Final rule.

SUMMARY: This amendment adopts a new airworthiness directive (AD), applicable to British Aerospace Model DH/BH/HS 125 series airplanes, that requires eddy current inspections and, if necessary, dye penetrant inspections of certain areas of the wing upper skins to detect cracks in the vicinity of countersunk bolt holes and in internal stringers; and repair, if necessary. This amendment is prompted by recent reports of cracks in countersunk bolt holes in left and right wing upper skins and internal stringers attached to the underside of the wing upper skins. The actions specified by this AD are intended to prevent reduced structural integrity of the wings.

DATES: Effective July 9, 1992.

The incorporation by reference of certain publications listed in the regulations is approved by the Director of the Federal Register as of July 9, 1992.

ADDRESSES: The service information referenced in this AD may be obtained from British Aerospace, PLC. Librarian for Service Bulletins, P.O. Box 17414, Dulles International Airport, Washington DC 20041-0414. This information may be examined at the Federal Aviation Administration (FAA), Transport Airplane Directorate, Rules

Docket, 1601 Lind Avenue SW., Renton, Washington; or at the Office of the Federal Register, 1100 L Street NW., room 8401, Washington, DC.

FOR FURTHER INFORMATION CONTACT:

William Schroeder, Standardization Branch, ANM-113, FAA, Transport Airplane Directorate, 1601 Lind Avenue SW., Renton, Washington 98055-4056; telephone (206) 227-2113; fax (206) 227-1320.

SUPPLEMENTARY INFORMATION: A proposal to amend part 39 of the Federal Aviation Regulations to include an airworthiness directive (AD) that is applicable to British Aerospace Model DH/BH/HS 125 series airplanes was published in the *Federal Register* on January 12, 1992 (57 FR 5082). That action proposed to require eddy current inspections and, if necessary, dye penetrant inspections of certain areas of the wing upper skins to detect cracks in the vicinity of countersunk bolt holes and in internal stringers; and repair, if necessary.

Interested persons have been afforded an opportunity to participate in the making of this amendment. No comments were submitted in response to the proposal or the FAA's determination of the cost to the public.

Certain references to British Aerospace Service Bulletin S.B. 57-75 that appeared in paragraphs (a), (b), and (c) of the proposal have been corrected in the final rule to specify "July 30, 1991" as the date of issuance (rather than July 31, 1991).

After careful review of the available data, the FAA has determined that air safety and the public interest require the adoption of the rule with the corrections previously described. The FAA has determined that these corrections will neither increase the economic burden on any operator nor increase the scope of the AD.

The FAA estimates that 133 airplanes of U.S. registry will be affected by this AD, that it will take approximately 12 work hours per airplane to accomplish the required actions, and that the average labor rate is \$55 per work hour. Based on these figures, the total cost impact of the AD on U.S. operators is estimated to be \$87,780.

The regulations adopted herein will not have substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government. Therefore, in accordance with Executive Order 12612, it is determined that this final rule does not have sufficient federalism implications

to warrant the preparation of a Federalism Assessment.

For the reasons discussed above, I certify that this action (1) is not a "major rule" under Executive Order 12291; (2) is not a "significant rule" under DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and (3) will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act. A final evaluation has been prepared for this action and it is contained in the Rules Docket. A copy of it may be obtained from the Rules Docket at the location provided under the caption "ADDRESSES."

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Incorporation by reference, Safety.

Adoption of the Amendment

Accordingly, pursuant to the authority delegated to me by the Administrator, the Federal Aviation Administration amends 14 CFR part 39 of the Federal Aviation Regulations as follows:

PART 39—AIRWORTHINESS DIRECTIVES

1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 1354(a), 1421 and 1423; 49 U.S.C. 106(g); and 14 CFR 11.89.

§ 39.13 [Amended]

2. Section 39.13 is amended by adding the following new airworthiness directive:

92-11-03. British Aerospace: Amendment 39-8253. Docket 91-NM-280-AD.

Applicability: British Aerospace Model DH/BH/HS 125 series airplanes, excluding Models 125-600A, -700A, -800A, and -1000A series airplanes; as listed in British Aerospace Service Bulletin S.B. 57-75, dated July 30, 1991; certificated in any category.

Compliance: Required as indicated, unless accomplished previously.

To prevent reduced structural integrity of the wings, accomplish the following:

(a) Within 3 months after the effective date of this AD, and thereafter at intervals not to exceed 4 years or 2,200 flights, whichever occurs first, perform an eddy current inspection on specified areas of the left and right wing upper skins to detect cracks in countersunk bolt holes in the wing skins and in the internal stringers, in accordance with British Aerospace Service Bulletin S.B. 57-75, dated July 30, 1991.

(b) If cracks are discovered as a result of the eddy current inspection required by paragraph (a) of this AD, prior to further flight, perform a dye penetrant inspection, in accordance with British Aerospace Service Bulletin S.B. 57-75, dated July 30, 1991.

(c) If cracks are discovered as a result of either the eddy current inspections required by paragraph (a) of this AD, or the dye penetrant inspection required by paragraph (b) of this AD, prior to further flight, repair the crack(s) as follows:

(1) Cracks that do not exceed the limits specified in British Aerospace Service Bulletin S.B. 57-75, dated July 30, 1991, must be repaired in accordance with the procedures in the Service Bulletin.

(2) Cracks that exceed the limits specified in British Aerospace Service Bulletin S.B. 57-75, dated July 30, 1991, must be repaired in accordance with a method approved by the Manager, Standardization Branch, ANM-113, FAA, Transport Airplane Directorate.

(d) An alternative method of compliance or adjustment of the compliance time, which provides an acceptable level of safety, may be used when approved by the Manager, Standardization Branch, ANM-113, FAA, Transport Airplane Directorate. The request shall be forwarded through an FAA Principal Maintenance Inspector, who may concur or comment and then send it to the Manager, Standardization Branch, ANM-113.

(e) Special flight permits may be issued in accordance with FAR 21.197 and 21.199 to operate the airplane to a location where the requirements of this AD can be accomplished.

(f) The inspections and repairs shall be done in accordance with British Aerospace Service Bulletin S.B. 57-75, dated July 30, 1991. This incorporation by reference was approved by the Director of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. Copies may be obtained from British Aerospace, PLC, Librarian for Service Bulletins, P.O. Box 17414, Dulles International Airport, Washington, DC 20041-0414. Copies may be inspected at the FAA, Transport Airplane Directorate, 1601 Lind Avenue SW., Renton, Washington; or at the Office of the Federal Register, 1100 L Street NW., room 8401, Washington, DC.

(g) This amendment becomes effective on July 9, 1992.

Issued in Renton, Washington, on April 28, 1992.

N.B. Martenson,

Acting Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. 92-13042 Filed 6-3-92; 8:45 am]

BILLING CODE 4910-13-M

14 CFR Part 39

[Docket No. 91-NM-281-AD; Amendment 39-8255; AD 92-11-05]

Airworthiness Directives; British Aerospace Viscount Model 744, 745D and 810 Series Airplanes

AGENCY: Federal Aviation Administration, DOT.

ACTION: Final rule.

SUMMARY: This amendment adopts a new airworthiness directive (AD), applicable to British Aerospace

Viscount Model 744, 745D and 810 series airplanes, that requires visual inspection of the upper boom of a wing rib for proper fastener edge distance, and, repair or replacement of the rib boom with a new part, if necessary. This amendment is prompted by reports of undersized end rib booms. The actions specified by this AD are intended to prevent reduced structural integrity of the engine mount attachment to the wing and wing structure.

DATES: July 9, 1992.

The incorporation by reference of certain publications listed in the regulations is approved by the Director of the Federal Register as of July 9, 1992.

ADDRESSES: The service information referenced in this AD may be obtained from British Aerospace, PLC, Librarian for Service Bulletins, P.O. Box 17414, Dulles International Airport, Washington, DC 20041-0414. This information may be examined at the Federal Aviation Administration (FAA), Transport Airplane Directorate, Rules Docket, 1601 Lind Avenue SW., Renton, Washington; or at the Office of the Federal Register, 1100 L Street NW., room 8401, Washington, DC.

FOR FURTHER INFORMATION CONTACT: Mr. William Schroeder, Standardization Branch, ANM-113, FAA, Transport Airplane Directorate, 1601 Lind Avenue SW., Renton, Washington 98055-4056; telephone (206) 227-2148; fax (206) 227-1320.

SUPPLEMENTARY INFORMATION: A proposal to amend part 39 of the Federal Aviation Regulations to include an airworthiness directive (AD) that is applicable to British Aerospace Viscount Model 744, 745D and 810 series airplanes was published in the Federal Register on February 12, 1992 (57 FR 5083). That action proposed to require visual inspection of the upper boom of a wing rib for proper fastener edge distance, and, repair or replacement of the rib boom with a new part, if necessary.

Interested persons have been afforded an opportunity to participate in the making of this amendment. No comments were submitted in response to the proposal or the FAA's determination of the cost to the public. The FAA has determined that air safety and public interest require the adoption of the rule as proposed.

The FAA estimates that 29 airplanes of U.S. registry will be affected by this AD, that it will take approximately 30 work hours per airplane to accomplish the required actions, and that the average labor rate is \$55 per work hour. Based on these figures, the total cost

impact of the AD on U.S. operators is estimated to be \$47,850.

The regulations adopted herein will not have substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government. Therefore, in accordance with Executive Order 12612, it is determined that this final rule does not have sufficient federalism implications to warrant the preparation of a Federalism Assessment.

For the reasons discussed above, I certify that this action (1) is not a "major rule" under Executive Order 12291; (2) is not a "significant rule" under DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and (3) will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act. A final evaluation has been prepared for this action and it is contained in the Rules Docket. A copy of it may be obtained from the Rules Docket at the location provided under the caption "ADDRESSES."

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Incorporation by reference, Safety.

Adoption of the Amendment

Accordingly, pursuant to the authority delegated to me by the Administrator, the Federal Aviation Administration amends 14 CFR part 39 of the Federal Aviation Regulations as follows:

PART 39—AIRWORTHINESS DIRECTIVES

1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 1354(a), 1421 and 1423; 49 U.S.C. 106(g); and 14 CFR 11.89.

§ 39.13 [Amended]

2. Section 39.13 is amended by adding the following new airworthiness directive:

92-11-05. British Aerospace: Amendment 39-8255. Docket 91-NM-281-AD.

Applicability: Viscount Model 744 and 745D series airplanes, post-mod D3070 and D3292; and Viscount Model 810 series airplanes, post-mod FG1925 and FG2172, certificated in any category.

Compliance: Required as indicated, unless accomplished previously. To prevent reduced structural integrity of the engine mount attachment to the wing and wing structure, accomplish the following:

(a) Within 100 landings or within 4 months after the effective date of this AD, whichever occurs earlier, visually inspect the upper

boom of the wing rib at wing station 257, left and right, for proper fastener edge distance, in accordance with British Aerospace Viscount Alert Preliminary Technical Leaflet (PTL) 192 or PTL 323, both dated January 31, 1990, as applicable.

(b) If any discrepancies are detected in the fastener edge distance, prior to further flight, replace the rib boom with a new part, or repair in a manner approved by the Manager, Standardization Branch, ANM-113, FAA, Transport Airplane Directorate.

(c) An alternative method of compliance or adjustment of the compliance time, which provides an acceptable level of safety, may be used when approved by the Manager, Standardization Branch, ANM-113, FAA, Transport Airplane Directorate. The request shall be forwarded through an FAA Principal Maintenance Inspector, who may concur or comment and then send it to the Manager, Standardization Branch, ANM-113.

(d) Special flight permits may be issued in accordance with FAR 21.197 and 21.199 to operate the airplane to a location where the requirements of this AD can be accomplished.

(e) The inspection and replacement shall be done in accordance with British Aerospace Viscount Alert PTL 192, Issue 1, dated January 31, 1990; or British Aerospace Viscount Alert PTL 323, Issue 1, dated January 31, 1990; as applicable.

(Note: The issue date of PTL 192 and PTL 323 is indicated only on "page 3 of 5" of each document; no other page of these documents is dated.) This incorporation by reference was approved by the Director of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. Copies may be obtained from British Aerospace, PLC, Librarian for Service Bulletins, P.O. Box 17414, Dulles International Airport, Washington, DC 20041-0414. Copies may be inspected at the FAA, Transport Airplane Directorate, 1601 Lind Avenue SW., Renton, Washington; or at the Office of the Federal Register, 1100 L Street NW., room 8401, Washington, DC.

(f) This amendment becomes effective on July 9, 1992.

Issued in Renton, Washington, on April 29, 1992.

N.B. Martenson,

Acting Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. 92-13045 Filed 6-3-92; 8:45 am]

BILLING CODE 4910-13-M

TENNESSEE VALLEY AUTHORITY

18 CFR Part 1301

Freedom of Information Act

AGENCY: Tennessee Valley Authority (TVA).

ACTION: Final rule.

SUMMARY: The Tennessee Valley Authority is amending its regulations to provide procedures for requesting a waiver or reduction of fees for records

requested through the Freedom of Information Act.

EFFECTIVE DATE: June 4, 1992.

FOR FURTHER INFORMATION CONTACT: Linda E. Blevins, Tennessee Valley Authority, 1101 Market Street (MR 2F), Chattanooga, TN 37402-2801, telephone number: (615) 751-2524.

SUPPLEMENTARY INFORMATION:

On February 24, 1992 (57 FR 6300-6301), TVA gave notice of its intention to amend its regulations to provide procedures for requesting a waiver or reduction of fees for records requested through the Freedom of Information Act. No comments were received in response to this notice. There are no substantive changes between the text of the proposed rule and the text of the final rule.

List of Subjects in 18 CFR Part 1301

Administrative practice and procedure, Freedom of information, Privacy act, Sunshine act.

For the reasons set forth in the preamble, title 18, chapter XIII of the Code of Federal Regulations is amended as follows:

PART 1301—PROCEDURES

1. The authority citation for part 1301, subpart A, continues to read as follows:

Authority: 16 U.S.C. 831-831dd, 5 U.S.C. 552.

2. Section 1301.3 is added to read as follows:

§ 1301.3 Waiver or reduction of fees.

(a) Records responsive to a request under 5 U.S.C. 552 shall be furnished without charge or at a charge reduced below that established under § 1301.2 where TVA determines, based upon information provided by a requester in support of a fee waiver request or otherwise made known to TVA, that disclosure of the requested information is in the public interest because it is likely to contribute significantly to public understanding of the operations or activities of the government and is not primarily in the commercial interest of the requester. Requests for a waiver or reduction of fees, which shall be made at the same time as the requests for records, shall be considered on a case-by-case basis.

(b) In order to determine whether the first fee waiver requirement is met—i.e., that disclosure of the requested information is in the public interest because it is likely to contribute significantly to public understanding of the operations or activities of the government—TVA shall consider the following four factors in sequence:

(1) The subject of the request: Whether the subject of the requested records concerns "the operations or activities of the government." The subject matter of the requested records, in the context of the request, must specifically concern identifiable operations or activities of the federal government—with a connection that is direct and clear, not remote or attenuated. Furthermore, the records must be sought for their informative value with respect to those government operations or activities; a request for access to records for their intrinsic informational content alone will not satisfy this threshold consideration.

(2) The informational value of the information to be disclosed: Whether the disclosure is "likely to contribute" to an understanding of government operations or activities. The disclosable portions of the requested records must be meaningfully informative on specific government operations or activities in order to hold potential for contributing to increased public understanding of those operations and activities. The disclosure of information that already is in the public domain, in either a duplicative or a substantially identical form, would not be likely to contribute to such understanding, as nothing new would be added to the public record.

(3) The contribution to an understanding of the subject by the public likely to result from disclosure: Whether disclosure of the requested information will contribute to "public understanding." The disclosure must contribute to the understanding of the public at large, as opposed to the individual understanding of the requester or a narrow segment of interested persons. A requester's identity and qualification—e.g., expertise in the subject area and ability and intention to effectively convey information to the general public—should be considered. It reasonably may be presumed that a representative of the news media (as defined in paragraph 1301.2(b)(7)) who has access to the means of public dissemination readily will be able to satisfy this consideration. Requests from libraries or other record repositories (or requesters who intend merely to disseminate information to such institutions) shall be analyzed, like those of other requesters, to identify a particular person who represents that he actually will use the requested information in scholarly or other analytic work and then disseminate it to the general public.

(4) The significance of the contribution to public understanding: Whether the disclosure is likely to contribute "significantly" to public

understanding of government operations or activities. The public's understanding of the subject matter in question, as compared to the level of public understanding existing prior to the disclosure, must be likely to be enhanced by the disclosure to a significant extent. TVA shall not make separate value judgments as to whether information, even though it in fact would contribute significantly to public understanding of the operations or activities of the government, is "important" enough to be made public.

(c) In order to determine whether the second fee waiver requirement is met—i.e., that disclosure of the requested information is not primarily in the commercial interest of the requester—TVA shall consider the following two factors in sequence:

(1) The existence and magnitude of a commercial interest: Whether the requester has a commercial interest that would be furthered by the requested disclosure. TVA shall consider all commercial interests of the requester (with reference to the definition of "commercial use" in paragraph 1301.2(b)(4)), or any person on whose behalf the requester may be acting, but shall consider only those interests which would be furthered by the requested disclosure. In assessing the magnitude of identified commercial interests, consideration shall be given to the role that such FOIA-disclosed information plays with respect to those commercial interests, as well as to the extent to which FOIA disclosures serve those interests overall. Requesters shall be given a reasonable opportunity in the administrative process to provide information bearing upon this consideration.

(2) The primary interest in disclosure: Whether the magnitude of the identified commercial interest of the requester is sufficiently large, in comparison with the public interest in disclosure, that disclosure is "primarily in the commercial interest of the requester." A fee waiver or reduction is warranted only where, once the "public interest" standard set out in paragraph (b) of this section is satisfied, that public interest can fairly be regarded as greater in magnitude than that of the requester's commercial interest in disclosure. TVA shall ordinarily presume that, where a news media requester has satisfied the "public interest" standard, that will be the interest primarily served by disclosure to that requester. Disclosure to data brokers or others who compile and market government information for direct economic return shall not be

presumed to primarily serve the "public interest."

(d) Where only a portion of the requested records satisfies both of the requirements for a waiver or reduction of fees under this paragraph, a waiver or reduction shall be granted only as to that portion.

(e) Requests for the waiver or reduction of fees shall address each of the factors listed in paragraphs (b) and (c) of this section, as they apply to each record request.

(f) A denial of a request for reduced fees or of a request for waiver of fees, in whole or in part, will be made in writing, will state the reasons for the denial, and will notify the requester of the right to appeal the denial. The appeal process for denial of a fee waiver or reduction of fees shall be identical to the appeal process for denial of a requested record and shall be subject to the procedures detailed in § 1301.1(c)(2).

Louis S. Grande,

Vice President, Information Services.

[FR Doc. 92-13111 Filed 6-3-92; 8:45 am]

BILLING CODE 8120-08-M

DEPARTMENT OF TRANSPORTATION

Coast Guard

33 CFR Part 100

[CGD 05-92-18]

Special Local Regulations for Marine Events; Norfolk Harborfest 1992; Norfolk Harbor, Elizabeth River, Norfolk and Portsmouth, VA

AGENCY: Coast Guard, DOT.

ACTION: Notice of implementation of special local regulations.

SUMMARY: This notice implements special local regulations for Norfolk Harborfest 1992, an annual event to be held in the Waterside area of the Elizabeth River between Norfolk and Portsmouth, Virginia. These special local regulations are needed to control vessel traffic within the immediate vicinity of Waterside due to the confined nature of the waterway and the expected vessel congestion during the Norfolk Harborfest 1992 activities. The effect will be to restrict general navigation in the regulated area for the safety of participants and spectators.

EFFECTIVE DATES: The regulations in 33 CFR 100.501 are effective for the following periods:

10 a.m. to 9 p.m., June 5, 1992.

8 a.m. to 11 p.m., June 6, 1992.

8:30 a.m. to 8:30 p.m., June 7, 1992.

If inclement weather causes the postponement of the fireworks display on June 6, 1992, the regulations will be in effect until 11 p.m., June 7, 1992.

FOR FURTHER INFORMATION CONTACT: Stephen L. Phillips, Chief, Boating Affairs Branch, Fifth Coast Guard District 431 Crawford Street, Portsmouth, Virginia 23705 (804) 398-6204, or Commander, Coast Guard Group Hampton Roads (804) 483-8559.

SUPPLEMENTARY INFORMATION:

Drafting Information

The drafters of this notice are QM1 Kevin R. Connors, project officer, Boating Affairs Branch, Boating Safety Division, Fifth Coast Guard District, and LT Monica L. Lombardi, project attorney, Fifth Coast Guard District Legal Staff.

Discussion of Regulation

Norfolk Harborfest, Inc. has submitted an application to hold Norfolk Harborfest 1992 on June 5, 6, and 7, 1992, in the Waterside area of the Elizabeth River. This area is covered by 33 CFR 100.501 and generally includes the waters of the Elizabeth River between Town Point Park, Norfolk, Virginia, the mouth of the Eastern Branch of the Elizabeth River, and Hospital Point, Portsmouth, Virginia. Since this event is of the type contemplated by this regulation and the safety of the participants and spectators viewing this event will be enhanced by the implementation of special local regulations for the Elizabeth River, 33 CFR 100.501 will be in effect during Norfolk Harborfest 1992 will consist of aerobic demonstrations, fireworks, and numerous other water events, to include a parade of sailboats and several boat and raft races. Because commercial vessels will be permitted to transit the regulated area between events, commercial traffic should not be severely disrupted. In addition to regulating the area for the safety of life and property, this notice of implementation also authorizes the Patrol Commander to regulate the operation of the Berkley drawbridge in accordance with 33 CFR 117.1007, and authorizes spectators to anchor in the special anchorage areas described in 33 CFR 110.72aa.

Dated: May 21, 1992.

W.T. Leland,

Rear Admiral, U.S. Coast Guard Commander, Fifth Coast Guard District.

[FR Doc. 92-12937 Filed 6-3-92; 8:45 am]

BILLING CODE 4910-14-M

33 CFR Part 100

[CGD1 92-013]

Ray Catena Mercedes-Benz Offshore Grand Prix, Manasquan, NJ

AGENCY: Coast Guard, DOT.

ACTION: Implementation rule.

SUMMARY: This document puts into effect the permanent regulations for the Ray Catena Mercedes-Benz Offshore Grand Prix. The regulations are necessary in order to control vessel traffic within the immediate vicinity of the event due to the hazards associated with powerboat racing and the anticipated congestion at the time of the event. The purpose of this regulation is to provide for the safety of life and property on navigable waters during the event.

EFFECTIVE DATE: The regulations are effective at 11:00 am on Saturday, July 25, 1992 and terminate at 3:00 pm on Saturday, July 25, 1992.

FOR FURTHER INFORMATION CONTACT: Lieutenant (junior grade) Eric G. Westerberg, Chief, Boating Safety Affairs Branch, First Coast Guard District, (617) 223-8310.

SUPPLEMENTARY INFORMATION: This notice provides the effective time period for the regulation governing the 1992 running of the Ray Catena Mercedes-Benz Offshore Grand Prix. The regulations, 33 CFR 100.109, will be in effect from 11:00 am on July 25, 1992 through 3:00 pm on July 25, 1992. The Ray Catena Mercedes-Benz Offshore Grand Prix is a high speed power boat race around a rectangular course. The race course is situated on the coastal waters of the Atlantic Ocean extending from Manasquan, NJ to Seaside Heights, NJ. Sponsor provided patrol craft will mark the spectator area which will be established from Manasquan Inlet northward for one half (1/2) mile. Vessels exiting Manasquan Inlet and wishing to transit the area will be directed to proceed north along the shore until clear of (north of) the regulated area. No vessels will be allowed to exit Manasquan Inlet in a southerly direction during the effective period of regulation. The regulated area will be patrolled by the U.S. Coast Guard, the Coast Guard Auxiliary, state and local law enforcement agencies and the sponsor. Further public notification, including the full text of the regulations will be accomplished through advance notice in the First Coast Guard District Local Notice to Mariners.

Drafting Information

The principal persons involved in drafting this document are LTJG E.G. Westerberg, Project Manager, First Coast Guard District Boating Safety Division, and LCDR J. Astley, Project Attorney, First Coast Guard District Legal Office.

Dated: May 15, 1992.

J.D. Sipes,

Rear Admiral, U.S. Coast Guard Commander, First Coast Guard District.

[FR Doc. 92-13105 Filed 6-3-92; 8:45 am]

BILLING CODE 4910-14-M

33 CFR Part 100

[CGD-09-92-05]

Special Local Regulations: Sodus Bay 4th of July Fireworks, Lake Ontario, Sodus Bay, Sodus Point, NY

AGENCY: Coast Guard, DOT.

ACTION: Temporary final rule.

SUMMARY: Special Local Regulations, which will restrict general vessel traffic, are being imposed in Sodus Bay for fireworks on the 3rd of July 1992. Because of the unusually large number of spectator craft in the area and falling ash and debris, which could pose hazards to navigation in the area, Special Local Regulations are necessary to ensure the safety of life and property during the fireworks display.

EFFECTIVE DATE: These regulations become effective from 9 p.m. until 11:30 p.m. (EDST) on July 3, 1992.

FOR FURTHER INFORMATION CONTACT: William A. Thibodeau, Marine Science Technician Third Class, U.S. Coast Guard, Aids to Navigation & Waterways Management Branch, Ninth Coast Guard District, 1240 East 9th Street, Cleveland, Ohio 44199-2060 (216) 522-4420.

SUPPLEMENTARY INFORMATION: In accordance with 5 U.S.C. 553, a Notice of Proposed Rule Making has not been published for these regulations and good cause exists for making them effective in less than 30 days from the date of publication. Following normal rulemaking procedures would have been impracticable. The application to hold this event was not received by the Commander, Ninth Coast Guard District, until 20 April 1992, and there was not sufficient time remaining to publish proposed rules in advance of the event or to provide for a delayed effective date.

Drafting Information

The drafters of this regulation are William A. Thibodeau, Marine Science

Technician Third Class, U.S. Coast Guard, project officer, Aids to Navigation & Waterways Management Branch and M. Eric Reeves, Commander, U.S. Coast Guard, project attorney, Ninth Coast Guard District Legal Office.

Discussion of Regulations

The Sodus Bay 4th of July Fireworks will be conducted on Sodus Bay, Lake Ontario on the 3rd of July 1992. Fireworks will be launched from an anchored barge in Sodus Bay. This event will have falling ash and debris, and an unusually large number of spectator craft in the area, which could pose hazards to navigation in the area. Any vessel desiring to transit the regulated area may do so only with prior approval of the Patrol Commander (Officer in Charge, U.S. Coast Guard Station Sodus Point, NY.).

Economic Assessment and Certification

This regulation is considered to be non-major under Executive Order 12291 on Federal Regulation and nonsignificant under Department of Transportation regulatory policies and procedures (44 FR 11034; February 26, 1979). The economic impact has been found to be so minimal that a full regulatory evaluation is unnecessary. This event will draw a large number of spectator craft into the area for the duration of the event. This should have a favorable impact on commercial facilities providing services to the spectators. Any impact on commercial traffic in the area will be negligible.

Since the impact of this regulation is expected to be minimal, the Coast Guard certifies that it will not have a significant economic impact on a substantial number of small entities.

Federalism

This action has been analyzed in accordance with the principles and criteria contained in Executive Order 12612, and it has been determined that this rulemaking does not have sufficient federalism implications to warrant the preparation of a Federalism Assessment.

List of Subjects in 33 CFR Part 100

Marine safety, Navigation (water).

Temporary Regulations

In consideration of the foregoing, part 100 of title 33, Code of Federal Regulations, is amended as follows:

PART 100—[AMENDED]

1. The authority citation for part 100 continues to read as follows:

Authority: 33 U.S.C. 1233; 49 CFR 1.46 and 33 CFR 100.35.

2. Temporary § 100.35-T0905 is added to read as follows:

§ 100.35 T0905 Sodus Bay 4th of July Fireworks, Lake Ontario, Sodus Bay, Sodus Point, NY.

(a) *Regulated Area.* A 500 foot radius around a barge anchored in position 43 degrees 15.73 minutes North, 076 degrees 58.23 minutes West, in Sodus Bay, Lake Ontario.

(b) *Special Local Regulations.* (1) The above area will be closed to vessel navigation and anchorage, except when expressly authorized by the Coast Guard Patrol Commander, from 9 p.m. (EDST) until 11:30 p.m. (EDST) on 3 July 1992.

(2) The Coast Guard will patrol the regulated area under the direction of a designated Coast Guard Patrol Commander. The Patrol Commander may be contacted on channel 16 (156.8 MHz) by the call sign "Coast Guard Patrol Commander". Any vessel, not authorized to participate in the event, desiring to transit the regulated area may do so only with prior approval of the Patrol Commander and when so directed by that officer.

(3) The Patrol Commander may direct the anchoring, mooring, or movement of any boat or vessel within the regulated area. A succession of sharp, short signals by whistle or horn from vessels patrolling the area under the direction of the U.S. Coast Guard Patrol Commander shall serve as a signal to stop. Any vessel so signaled shall stop and shall comply with the orders of the Patrol Commander. Failure to do so may result in expulsion from the area, citation for failure to comply, or both.

(4) The Patrol Commander may terminate the marine event or the operation of any vessel at any time it is deemed necessary for the protection of life and property.

Dated: May 5, 1992.

G.A. Penington,

Rear Admiral, U.S. Coast Guard, Commander, Ninth Coast Guard District.

[FR Doc. 92-13104 Filed 6-3-92; 8:45 am]

BILLING CODE 4910-14-M

33 CFR Part 165

[COTP Jacksonville, FL Regulation 92-48]

Safety Zone Regulations; St. Johns River, Jacksonville, FL

AGENCY: Coast Guard, DOT.

ACTION: Temporary final rule.

SUMMARY: The Coast Guard is establishing a safety zone on the St. Johns River in Jacksonville, FL for all waters 500 feet on either side of the Old Acosta Bridge from 13 May 1992 until 21 August 1992. The zone will be activated and deactivated, in whole or in part, as needed to protect the public from possible harm resulting from demolition operations to remove the Old Acosta Bridge. Entry into the specified zone, when activated, is prohibited. All other time periods, mariners should exercise caution while transiting throughout the area.

EFFECTIVE DATES: This regulation is effective from May 13, 1992 to August 21, 1992.

FOR FURTHER INFORMATION CONTACT: Lieutenant Commander Mike Maes, Tel: (904) 791-2648.

SUPPLEMENTARY INFORMATION: In accordance with 5 U.S.C. 553, a notice of proposed rulemaking was not published for this regulation and good cause exists for making it effective in less than 30 days after Federal Register publication. Publishing an NPRM and delaying its effective date would be contrary to the public interest since immediate action is needed to prevent injury to the public and provide a clear work area for demolition contractors.

Drafting Information

The drafters of this regulation are Lieutenant Junior Grade Theodore J. Ferring, project officer for the Captain of the Port, and Lieutenant Jacqueline M. Lasago, project attorney, Seventh Coast Guard District Legal Office.

Discussion of Regulation

The event requiring this regulation is the demolition of the Old Acosta Bridge. The zone is needed to protect the public from possible harm resulting from the use of high explosives used in demolishing large concrete structures, and to provide demolition contractors with a clear area to complete the task safely. During this period it is estimated that the zone, in whole or in part, will be activated approximately 18 times, but only for a short duration of not more than two hours. Entry into the specified zone, when activated, is prohibited. This regulation is issued pursuant to 33 U.S.C. 1225 and 1231.

Federalism

This action has been analyzed in accordance with the principles and criteria contained in Executive Order

12612, and it has been determined that the proposed rulemaking does not have sufficient federalism implications to warrant the preparation of a Federalism Assessment.

List of Subjects in 33 CFR Part 165

Harbors, Marine safety, Navigation (water), Security measures, Vessels, Waterways.

Regulation

In consideration of the foregoing, subpart C of part 165 of title 33, Code of Federal Regulations, is amended as follows:

PART 165—[AMENDED]

1. The authority citation for part 165 continues to read as follows:

Authority: 33 U.S.C. 1231; 50 U.S.C. 191; 49 CFR 1.46 and 33 CFR 1.05-1(g), 6.04-1, 6.04-6, and 160.5.

2. A new § 165.T0800 is added to read as follows:

§ 165.T0800 Safety Zone: St. Johns River, Jacksonville, Florida.

(a) *Location.* The following area is a safety zone: As directed by the Captain of the Port Jacksonville, all waters, or any portion specified therein, of the St. Johns River within an overall area ranging bank to bank and 500 feet in both directions of the Old Acosta Bridge in downtown Jacksonville, FL.

(b) *Effective date.* This regulation is effective from May 13, 1992 to August 21, 1992. The zone, in whole or in part, will be activated as directed by the Captain of the Port Jacksonville via broadcast notice to mariners with a minimum two hour notification.

(c) *Regulations.* (1) In accordance with the general regulations in § 165.23 of this part, entry into this zone is prohibited unless authorized by the Captain of the Port.

(2) This section does not apply to authorized law enforcement agencies and demolition contractors operating within the Safety Zone.

Dated: May 12, 1992.

J. P. Wysocki,

Captain, U.S. Coast Guard, Captain of the Port, Jacksonville, Florida.

[FR Doc. 92-12938 Filed 6-3-92; 8:45 am]

BILLING CODE 4910-14-M

National Highway Traffic Safety Administration**49 CFR Part 544**

[Docket No. 91-53 Notice 2]

RIN 2127-AE23

Insurer Reporting Requirements; List of Insurers Required To File Reports

AGENCY: National Highway Traffic Safety Administration (NHTSA), Department of Transportation (DOT).

ACTION: Final rule.

SUMMARY: Title VI of the Motor Vehicle Information and Cost Savings Act requires certain passenger motor vehicle insurers to file reports with NHTSA, unless the agency exempts the insurer from filing such reports. The law stipulates that NHTSA can only exempt those insurance companies whose market share is below certain percentages for the nation as a whole and in each individual State, or for which NHTSA determines that: (1) The cost of preparing and furnishing such reports is excessive in relation to the size of the business of the insurer; and (2) the insurer's report will not significantly contribute to carrying out the purposes of title VI.

To carry out these statutory provisions, the agency has exempted those companies that are lawfully eligible to be exempted and is hereby publishing an updated listing of those companies subject to the reporting requirements. Using a new procedure, this notice updates the list of companies subject to the reporting requirements, to reflect changing market conditions. The final rule was preceded by a notice of proposed rulemaking published on October 16, 1991 (56 FR 51871) that requested public comment on the proposal.

EFFECTIVE DATE: The final rule on this subject is effective July 6, 1992. Companies listed on the appendices are required to submit reports beginning with the one due October 25, 1992.

FOR FURTHER INFORMATION CONTACT: Ms. Barbara A. Gray, Office of Market Incentives, NHTSA, 400 Seventh Street SW., Washington, DC 20590. Ms. Gray's telephone number is (202) 366-1740.

SUPPLEMENTARY INFORMATION:**Background**

Section 612 of the Motor Vehicle Information and Cost Savings Act (the Act) (15 U.S.C. 2032) requires certain passenger motor vehicle insurers to file an annual report with NHTSA unless the agency exempts the insurer from filing such reports. The reports include

information about thefts and recoveries of motor vehicles, the rating rules used by the insurers to establish premiums for comprehensive coverage, the actions taken by insurers to reduce such premiums, and the actions taken by insurers to reduce or deter theft. Under the Act, the following insurers are subject to the reporting requirements: (1) Those issuers of motor vehicle insurance policies whose total premiums account for one percent or more of the total premiums of motor vehicle insurance issued within the United States; (2) those issuers of motor vehicle insurance policies whose premiums account for 10 percent or more of total premiums written within any one State; (3) rental or leasing companies with a fleet of 20 or more vehicles not covered by theft insurance policies issued by insurers of motor vehicles, other than any governmental entity. As discussed in the following sections, the agency may, by regulation, exempt certain insurers from the reporting requirements.

A. Insurers of Passenger Motor Vehicles

Although issuers of motor vehicle insurance policies are subject to reporting requirements, section 612(a)(5) provides that the agency shall exempt small insurers from the reporting requirements if NHTSA finds that such exemptions will not significantly affect the validity or usefulness of the information collected and compiled in the reports, either nationally or on a State-by-State basis. The term "small insurer" is defined in section 612(a)(5)(C) as an insurer whose premiums account for less than 1 percent of the total premiums for all forms of motor vehicle insurance issued by insurers within the United States. However, that section also stipulates that if an insurance satisfies this definition of a "small insurer," but accounts for 10 percent or more of the total premiums for all forms of motor vehicle insurance issued by insurers within a particular State, such an insurer must report the required information about its operations in that State.

As described in the final rule establishing the requirement for insurer reports (52 FR 59, January 2, 1987), appendix A lists companies which must report based on the fact that each insurer had at least one percent of the national market for motor vehicle insurance premiums, and appendix B lists those insurers that are required to report for particular states because each insurer had a 10 percent or greater market share of motor vehicle premiums in those States. In the January 2, 1987 notice, the agency stated that these appendices will be updated annually. It

has been NHTSA's practice to update the appendices based on data voluntarily provided by insurance companies to A.M. Best, and made available to the agency each spring. The agency uses the data to determine the insurers' market shares nationally and in each state.

B. Self-Insured Rental and Leasing Companies

In addition to companies that issue insurance policies, the term "insurers" is defined in section 612 of the Act to include certain self-insurers, i.e., any person who has a fleet of 20 or more motor vehicles (other than any governmental entity) which are used primarily for rental or lease and which are not covered by theft insurance policies issued by insurers of passenger motor vehicles. (Section 612(a)(3)). Section 612(a)(4) of the Act authorizes the agency to exempt an insurer from submitting the reports, if the agency determines that:

(1) The cost of preparing and furnishing such reports is excessive in relation to the size of the business of the insurer, and

(2) The insurer's report will not significantly contribute to carrying out the purposes of title IV.

In a final rule dated June 22, 1990 (55 FR 25606), the agency in effect granted a class exemption to all companies that rent or lease fewer than 50,000 vehicles. The agency issued this exemption because it believed that reports from the largest rental and leasing companies would provide the agency with a representative sampling of the theft experience of rental and leasing companies. NHTSA concluded that reports by the many smaller rental and leasing companies do not significantly contribute to carrying out title VI, and that exempting such companies will relieve an unnecessary burden on the vast majority of the companies presently subject to the reporting requirements. As a result of the June 1990 final rule, a new appendix C, which consists of an annually updated listing of the rental and leasing companies that are subject to the reporting requirements in part 544, was added. It has been NHTSA's practice to update appendix C based primarily on information contained in the publications *Automotive Fleet Magazine* and *Travel Business Travel News*.

October 1991 Notice of Proposed Rulemaking

On October 16, 1991, NHTSA published a notice of proposed rulemaking (NPRM) to update the list of insurers required to file reports, based

on the most recent information. (See 56 FR 51871.) In that notice, the agency also proposed a new procedure that the agency believed would let insurers know well in advance of the annual October 25 filing date whether they need to file a report for the previous calendar year.

In the past, it was the agency's practice to attempt to update Appendices A, B and C each year prior to the October 25 filing date, using A.M. Best and other data obtained in the spring of that same calendar year. However, the agency was generally unable to complete the updating before the October 25 filing date, resulting in confusion concerning which companies needed to file reports.

In the October 1991 NPRM, NHTSA stated that it believed that this problem would be resolved by increasing the interval between the receipt of data and the reporting data. Under the new approach, the updating of the appendices would focus on the report due the year after receipt of the A.M. Best and other data, both for companies which are added to the lists and companies which are removed from the lists. The agency stated that, under this approach, all companies added to the lists as of the last update (March 1991 final rule) should file the required report by October 25, 1991, and all companies added to the lists by the final rule based on the October 1991 NPRM would be provided ample notice concerning whether they need to file a report by October 25, 1992.

The agency further noted that part 544 would not need to be changed to implement this approach. Part 544 generally does not limit its requirements to particular years. Under that part, any company not listed has an indefinite exemption from the reporting requirements, and as long as any company is listed, it must file reports each October 25. Thus, any company listed in the appendices as of the date of the notice of proposed rulemaking (October 16, 1991) must file a report on October 25, 1991, and each succeeding October 25, absent a further amendment.

NHTSA requested comments on this approach, and in particular, on whether there are any other ways to eliminate the problem discussed above.

NHTSA also proposed that, based on 1989 calendar year A.M. Best data, two companies, CIGNA Group and Crum and Forster Companies, included in Appendix A, be removed, and one company, Prudential of America Group, be added. Also based on the 1989 Best data, the agency proposed that one

company, Island Insurance Group (reporting on its activities in Hawaii) be removed from appendix B and that one company, Tennessee Farmers (reporting on its activities in Tennessee) be added. The agency further proposed that Southern Farm Bureau Casualty Group, already included in appendix B and required to report on its activities in Mississippi, also be required to report on its activities in Arkansas.

Based on information in *Automotive Fleet Magazine* and *Travel Trade Business Travel News* for 1989, NHTSA proposed that the following six rental and leasing companies be removed from appendix C: Automotive Rentals, Inc. (subsidiary of ARI, Inc.), Enterprise Rent-A-Car, GE Capital Auto Lease, Inc., Lend Lease Cars, Security Pacific Auto Finance, and United States Fleet Leasing, Inc. Based on additional information provided by each respective company that it self-insures fewer than 50,000 vehicles per year, the agency proposed to remove from appendix C two additional companies, Automotive Rentals, Inc. and United States Fleet Leasing, Inc. The agency also proposed that one company, Associates Leasing, Inc. be added to appendix C.

Public Comment and Final Determination

In response to the NPRM, the agency received one public comment, from Lease Plan U.S.A., Inc. Lease Plan stated that it should be removed from appendix C because it has on lease in the United States 12,000 vehicles and does not self-insure any of the vehicles. Because Lease Plan U.S.A. has fewer than 50,000 vehicles in its fleet and does not self-insure any of its vehicles, it does not meet the criteria the agency uses to determine that an insurer is included in appendix C. Therefore, the agency agrees that Lease Plan U.S.A. should be removed from appendix C.

Since the agency received no comment on the proposed change in the procedure updating appendices A, B and C, the agency adopts as final the procedure proposed in the NPRM. Henceforth, any company listed in the appendices must file a report in the forthcoming October 25 and each succeeding October 25, absent a further amendment. Therefore, each company listed in appendix A, B, or C of this notice must file a report no later than October 25, 1992, and, on each succeeding October 25, absent a further amendment.

This final rule does not have any retroactive effect, and it does not preempt any State law. Section 610 of the Motor Vehicle Information and Cost Savings Act, 15 U.S.C. 2030, provides

that judicial review of this rule may be obtained pursuant to Section 504 of the Cost Savings Act, 15 U.S.C. 2004. The Cost Savings Act does not require submission of a petition for reconsideration or other administrative proceedings before parties may file suit in court.

Regulatory Impacts

1. *Costs and Other Impacts.* NHTSA has analyzed this rule and determined that it is neither "major" within the meaning of Executive Order 12291 nor "significant" within the meaning of the Department of Transportation regulatory policies and procedures. This final rule implements the agency's policy of ensuring that all insurance companies that are statutorily eligible for exemption from the insurer reporting requirements are in fact exempted from those requirements. On the other hand, those companies that are not statutorily eligible for an exemption are expressly required to file reports.

NHTSA does not believe that this rule, reflecting more current data, affects the impacts described in the final regulatory evaluation prepared for 49 CFR part 544. Accordingly, a separate regulatory evaluation has not been prepared for this rulemaking action. Using the cost estimates in the final regulatory evaluation for part 544, the agency estimates that it will cost any company that is added to appendix A about \$50,000, any company added to appendix B about \$20,000, and any company added to appendix C about \$5,770. In this final rule, for appendix A, the agency removes one company and adds one company, for appendix B, the agency removes one company, adds one company, and requires reporting for an additional state for another company already reporting on its activities in one state, and for appendix C, the agency removes seven companies and adds one. The agency therefore estimates that the net effect of this proposal will be a cost savings to insurers, as a group, of approximately \$64,620.

As noted above, a full regulatory evaluation was prepared for the final rule establishing 49 CFR part 544. Interested persons may wish to examine that evaluation in connection with this rule. Copies of that evaluation have been placed in Docket No. T86-01; Notice 2. Any interested person may obtain a copy of this evaluation by writing to NHTSA, Docket Section, room 5109, 400 Seventh Street SW., Washington, DC 20590, or by calling at (202) 366-4949.

2. *Paperwork Reduction Act.* The information collection requirements in this rule have been submitted to and

approved by the Office of Management and Budget (OMB) pursuant to the requirements of the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*) This collection of information has been assigned OMB Control Number 2127-0547 ("Insurer Reporting Requirements") and has been approved for use through October 31, 1993.

3. *Regulatory Flexibility Act.* The agency has also considered the effects of this rulemaking under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) I certify that the final rule will not have a significant economic impact on a substantial number of small entities. The rationale for the certification is that none of the companies on appendices A, B, or C would be construed to be a small entity within the definition of the RFA. Section 612(a)(5)(C) of the Theft Act defines "small insurer" in part as any insurer whose premiums for motor vehicle insurance account for less than one percent of the total premiums for all forms of motor vehicle insurance issued by insurers within the United States, or any insurer whose premiums within any State, account for less than 10 percent of the total premiums for all forms of motor vehicle insurance issued by insurers within the State. In addition, the agency has exempted, by rule, all "self insured rental and leasing companies" that have fleets in excess of 50,000 vehicles.

4. *Federalism.* This action has been analyzed in accordance with the principles and criteria contained in Executive Order 12612, and it has been determined that the final rule does not have sufficient federalism implications to warrant the preparation of a Federalism Assessment.

5. *Environmental Impacts.* In accordance with the National Environmental Policy Act, NHTSA has considered the environmental impacts of this rule and determined that it will not have a significant impact on the quality of the human environment.

List of Subjects in 49 CFR Part 544

Crime insurance, insurance, insurance companies, motor vehicles, reporting and recordkeeping requirements.

In consideration of the foregoing, 49 CFR part 544 is amended as follows:

PART 544—[AMENDED]

1. The authority citation for part 544 continues to read as follows:

Authority: 15 U.S.C. 2032; delegation of authority at 49 CFR 1.50.

2. Appendix A to part 544 is revised to read as follows:

Appendix A—Insurers of Motor Vehicle Insurance Policies Subject to the Reporting Requirements in Each State in Which They Do Business

Aetna Life & Casualty Group
Allstate Insurance Group
American Family Group
American International Group
California State Auto Association
CNA Insurance Companies
Farmers Insurance Group
Geico Corporation Group
Hanover Insurance Companies
Hartford Insurance Group
Liberty Mutual Group
Nationwide Group
Progressive Group
Prudential of America Group
State Farm Group
Travelers Insurance Group
United States F & G Group
USAA Group

3. Appendix B to part 544 is revised to read as follows:

Appendix B—Issuers of Motor Vehicle Insurance Policies Subject to the Reporting Requirements Only in Designated States

Alfa Insurance Group (Alabama)
Amica Mutual Insurance Company (Rhode Island)
Auto Club of Michigan Group (Michigan)
Commercial Union Insurance Companies (Maine)
Concord Group Insurance Companies (Vermont)
Erie Insurance Group (Pennsylvania)
Indiana Farm Bureau Group (Indiana)
Kentucky Farm Bureau Group (Kentucky)
Southern Farm Bureau Casualty Group (Arkansas, Mississippi)
Tennessee Farmers (Tennessee)

4. Appendix C to part 544 is revised to read as follows:

Appendix C—Motor Vehicle Rental and Leasing Companies (Including Licensees and Franchisees) Subject to the Reporting Requirements of Part 544

Alamo Rent-A-Car, Inc.
American International Rent-A-Car Corp./ ANSA
Associates Leasing, Inc.
Avis, Inc.
Budget Rent-A-Car Corporation
Dollar Rent-A-Car Systems, Inc.
GE Capital Fleet Services
Hertz Rent-A-Car Division (subsidiary of Hertz Corporation)
McCullagh Leasing, Inc.
National Car Rental System, Inc.
Penske Truck Leasing Company
PHH Fleet America
Rental Concepts, Inc.
Ryder Truck Rental (both rental and leasing operations)
U-Haul International, Inc. (subsidiary of AMERCO)
Wheels, Inc.

Issued on: May 29, 1992.

Jerry Ralph Curry,
Administrator.

[FR Doc. 92-13011 Filed 6-3-92; 8:45 am]

BILLING CODE 4910-59-M

INTERSTATE COMMERCE COMMISSION

49 CFR Part 1332

[Ex Parte No. MC-205]

Earlier Disposal of Postal Contracts Filed With the Commission by the U.S. Postal Service

AGENCY: Interstate Commerce Commission.

ACTION: Final rule.

SUMMARY: The Commission modifies its regulations to eliminate the requirement that the United States Postal Service (Postal Service) file with the Commission copies of contracts between the Postal Service and common carriers providing transportation of mail. In lieu of the filing requirement, the Commission will require the Postal Service to supply copies of such contracts to the Commission, upon request, by FAX, messenger service or overnight mail. The Postal Service maintains contracts for public inspection and retains them until cancellation. The public rarely, if ever, asks to review such contracts at the Commission. The modified regulations will eliminate the Postal Service's costs for filing several thousand contracts a year with the Commission, as well as the Commission's costs for processing and storing those contracts, while continuing to fulfill the statutory requirement that postal contracts be available for inspection at the Commission.

EFFECTIVE DATE: This rule is effective July 6, 1992.

FOR FURTHER INFORMATION CONTACT:

James W. Greene (202) 927-5597

or

Charles E. Langyher, III (202) 927-5160
[TDD for hearing impaired: (202) 927-5721]

SUPPLEMENTARY INFORMATION: By notice of proposed rulemaking (NPR) served February 13, 1992 (57 FR 5413, February 14, 1992), the Commission proposed to discontinue its practice of retaining postal contracts past their effective date. Additionally, the Commission requested comments on whether it may and should amend 49 CFR 1332.3(b) to eliminate the requirement that the Postal Service file copies of the contracts.

The Association of American Railroads (AAR), The National Industrial Transportation League (NITL) and the National Star Route Mail Contractors' Association (NSRMCA) filed comments in response to the NPR. All three parties supported the proposal to dispose of the contracts after their

effective dates. NSRMCA did not respond to the request for comments on the feasibility of eliminating the filing requirement; AAR indicated that the statute appears to preclude total elimination of the requirement, but permits us to require the filing of only one copy (the regulations currently require two copies); and NITL stated that in its view we can eliminate the filing requirement.

In its comments, NITL points out that the Postal Reorganization Act, Public Law 91-375, does not require that postal contracts be "filed" with the Commission; rather, it merely requires that they be "available for inspection" at the Commission at least fifteen days prior to their effective dates. NITL contends that, in this day and age, the "availability" of contracts for inspection at the ICC can be accomplished without the actual physical filing and retention of all such documents at the Commission. For example, NITL states that the Commission and the Postal Service could enter into an understanding that, in the rare event there is a request for review of a contract at the Commission, the Postal Service would either FAX the contract to the Commission or send a copy by messenger.

The Commission believes that procedures along the lines suggested by NITL will produce cost savings for both the Postal Service and the Commission, while continuing to fulfill the statutory requirement that proposed postal contracts be available for inspection at the Commission at least 15 days prior to their effective dates. Postal Service personnel have informally indicated that the Postal Service will send us copies of the relevant contracts, upon request. The Commission therefore finds that 49 CFR Part 1332 should be amended by eliminating the existing filing requirement and substituting therefor a requirement that the Postal Service provide the Commission with copies of proposed contracts, upon request.

Energy and Environmental Considerations

This action will not have a significant impact upon the quality of the human environment or the conservation of energy resources.

Regulatory Flexibility Analysis

This action will not have a significant impact on a substantial number of small entities.

List of Subjects in 49 CFR Part 1332

Government contracts, Motor carriers, Postal Service, Railroads.

Decided: May 27, 1992.

By the Commission, Chairman Philbin, Vice Chairman McDonald, Commissioners Simmons, Phillips and Emmett. Commissioner Simmons concurred in the result with a separate expression.

Sidney L. Strickland, Jr.,
Secretary.

For the reasons set forth in the preamble, the Commission amends title 49, chapter X, part 1332 as follows:

**PART 1332—FILING CONTRACTS FOR
SURFACE MAIL TRANSPORTATION**

1. The authority citation for part 1332 continues to read as follows:

Authority: Sec. 5005(b)(3), 84 Stat. 767, 39 U.S.C. 5005.

2. A new § 1332.2 is added to read as follows:

§ 1332.2 Availability of contracts.

Upon request from any member of the public to inspect a contract(s) or agreement(s) described in § 1332.1, at any time between the effective date of such contract(s) or agreement(s) and 15 days prior thereto, the Commission will obtain the requested contract(s) or agreement(s) from the U.S. Postal Service and make it (them) available for inspection.

3. Section 1332.3 is revised to read as follows:

§ 1332.3 Manner of submitting contracts.

The U.S. Postal Service will submit to the Commission, upon request, a copy of the requested contract(s) or agreement(s). Such contract(s) or agreement(s) will be submitted by facsimile transmission or messenger service where feasible, and, where such services are not feasible, by the fastest available mail service.

[FR Doc. 92-13089 Filed 6-3-92; 8:45 am]

BILLING CODE 7035-01-M

Proposed Rules

Federal Register

Vol. 57, No. 108

Thursday, June 4, 1992

This section of the FEDERAL REGISTER contains notices to the public of the proposed issuance of rules and regulations. The purpose of these notices is to give interested persons an opportunity to participate in the rule making prior to the adoption of the final rules.

DEPARTMENT OF AGRICULTURE

Animal and Plant Health Inspection Service

9 CFR Parts 160, 161, and 162

[Docket No. 91-027]

Accreditation of Veterinarians

AGENCY: Animal and Plant Health Inspection Service, USDA.

ACTION: Proposed rule.

SUMMARY: We are proposing to revise the regulations by which we accredit veterinarians and authorize them to perform, on behalf of the Animal and Plant Health Inspection Service, certain animal health activities specified in 9 CFR chapter I. These changes would establish accreditation on a national rather than a State basis, and would also remove a test currently required for accredited veterinarians, require an orientation program for each newly accredited veterinarian, and specify standards for performance of certain services by accredited veterinarians. We also propose to revise procedures for suspending and revoking accredited veterinarian status, and to add language describing how civil and criminal penalties may be imposed on accredited veterinarians who violate regulatory requirements. These proposed changes are intended to ensure that an adequate number of qualified accredited veterinarians are available in the United States to perform necessary animal health activities. These changes would affect currently accredited veterinarians and future applicants for accredited veterinarian status.

DATES: Consideration will be given only to comments received on or before July 6, 1992.

ADDRESSES: To help ensure that your written comments are considered, send an original and three copies to Chief, Regulatory Analysis and Development, PPD, APHIS, USDA, room 804, Federal Building, 6505 Belcrest Road, Hyattsville, MD 20782. Please state that

your comments refer to Docket Number 91-027. Comments received may be inspected at USDA, room 1141, South Building, 14th Street and Independence Avenue SW., Washington, DC, between 8 a.m. and 4:30 p.m., Monday through Friday, except holidays.

FOR FURTHER INFORMATION CONTACT:

Dr. J. A. Heamon, Staff Veterinarian, Sheep, Goat, Equine, and Poultry Diseases Staff, VS, APHIS, USDA, room 769, Federal Building, 6505 Belcrest Road, Hyattsville, MD 20782, (301) 436-6954.

SUPPLEMENTARY INFORMATION:

Background

In accordance with 9 CFR parts 160, 161, and 162 (referred to below as the regulations), some veterinarians are accredited by the Federal government to cooperate with the Animal and Plant Health Inspection Service (APHIS) in controlling and preventing the spread of animal diseases throughout the country and internationally. Accredited veterinarians use their professional training in veterinary medicine to perform certain regulatory tasks. The proposed regulations would change the requirements for becoming accredited, the standards for performance of duties by accredited veterinarians, the rules of practice governing revocation and suspension of accredited veterinarians, and some definitions.

APHIS is responsible for defining the scope of the accredited veterinarian program, providing information and education regarding the program to veterinary practitioners participating as accredited veterinarians, and providing information to cooperating State governments, international partners, and the public. In addition, APHIS is responsible for enforcement of the veterinary accreditation standards contained in the regulations.

Accredited veterinarians are involved in a cooperative relationship with APHIS for disease control and prevention. Licensed veterinarians are presumed to be medically competent; accreditation in addition to licensing indicates that the accredited veterinarian is able and authorized to perform various procedures of regulatory animal health.

State governments have a role in the accredited veterinarian program through licensing and disseminating information on the accredited veterinarian program

to veterinary practitioners. States also have an advisory and consultative role in the adjudication process for accredited veterinarians who violate the standards of the regulations. However, the ultimate determination of the adjudicatory sanctions in such cases rests with the Federal Government.

According to current § 161.2, veterinarians must become accredited in each State where they intend to do accredited work. We propose to change this to a national accreditation; once veterinarians are accredited, they could perform accredited work in any State in which they were licensed to practice veterinary medicine.¹ This new national accreditation would increase the efficiency of the accreditation process by decreasing the amount of record keeping, since veterinarians would only need to be accredited once instead of State-by-State. This would decrease the burden on veterinarians who relocate to another State, who work near borders between States, or work in several States on a consultant basis. As a national service, APHIS would be able to keep a single national record of accredited veterinarians rather than utilizing the variety of State records.

Section 161.2 of the current regulations requires veterinarians desiring accreditation to take a written test as a part of the accreditation application procedure. APHIS is proposing to remove that test because it is not an accurate indication of qualification for accreditation.

Basic professional skills necessary for accreditation are learned in veterinary school, and the curricula of many veterinary schools include components designed to provide the basic animal science and regulatory procedural skills needed to successfully perform accredited veterinarian duties. APHIS works with schools of veterinary medicine to make this training available and to ensure that it is complete, current, and accurate.

However, some veterinary schools do not provide such training, and some graduates of veterinary schools may not

¹ We also propose that if an accredited veterinarian wishes to perform accredited duties in a State other than the one in which he or she was first accredited, the Veterinarian-in-Charge of the new State will have the accredited veterinarian complete an orientation in procedures used in the new State before the accredited veterinarian may perform accredited duties in that State.

have completed it. To address this situation, we propose to revise the procedure by which veterinarians apply for accreditation by adding a requirement to § 161.2 that APHIS confirm that the applicant's veterinary school coursework prepared the applicant to perform the tasks required of an accredited veterinarian. Under the proposed application procedure, when an applicant completes VS Form 1-36A, "Application for Veterinary Accreditation," the applicant would also certify that he or she is able to perform the following tasks listed in proposed § 161.2(d). After each task, we explain why the accredited veterinarian needs to be able to perform it.

1. *Perform physical examination of individual animals, herds, or flocks to determine whether they are free from communicable diseases.* One of the most frequent tasks of accredited veterinarians is to examine animals singly or in groups in order to sign certificates or other documents accurately describing their apparent state of health.

2. *Recognize the common breeds of livestock so as to be able to record breed information on official documents.* Needed to accurately record breed information on official documents, for identification and because some animal diseases afflict certain breeds more than other breeds.

3. *Recognize brucellosis tattoos and calfhood vaccination tags, and determine the state of origin or eartags, to properly identify animals in interstate commerce.* One of the primary means of enforcing the brucellosis program and other animal disease programs rests with accredited veterinarians checking these forms of official animal identification during examinations of animals in commerce.

4. *Estimate the age of livestock using dental formula.* Several APHIS programs restrict the movement of animals, particularly horses and cattle, if they are over or under a specified age and regulatory conditions have not been met. Accredited veterinarians may need to estimate the age of animals in situations where documentation of age is not available or may not be trustworthy.

5. *Apply an eartag, tattoo, backtag, and legband.* These identifications are used in many APHIS programs to show that animals have met specific requirements or are in a particular regulatory category. Accredited veterinarians are often responsible for applying these identifications.

6. *Certify the disease status of a poultry flock with regard to disease caused by *Salmonella enteritidis*,*

psittacosis or ornithosis, and velogenic viscerotropic Newcastle disease. Under some circumstances, poultry flocks may only ship birds after an accredited veterinarian has certified the flock is free from certain communicable avian diseases.

7. *Properly complete certificates for domestic and international movement of animals.* These documents are issued by accredited veterinarians and are used to enforce APHIS regulatory programs, and their accuracy is essential to the success of those programs.

8. *Apply and remove official seals.* These seals are used on means of conveyance or facilities to reveal whether articles prohibited movement due to a risk of animal disease are in fact moved.

9. *Perform a necropsy on livestock.* Necropsy is sometimes necessary to obtain, for official documents, information about an animal's disease status.

10. *Recognize signs and lesions of exotic animal diseases.* Preventing introduction of foreign animal diseases is a primary goal of APHIS programs. Since accredited veterinarians are likely to be the first to see evidence of introduced foreign diseases, it is important that they are able to recognize them.

11. *Plan a disease control strategy for a livestock unit.* Accredited veterinarians must be able to work with animal owners to develop plans to control communicable animal diseases that are discovered in the course of official business.

12. *Vaccinate for brucellosis and fill out the vaccination certificate.* Vaccinating animals and documenting the vaccination are critical parts of the APHIS brucellosis program, and these duties are often performed by accredited veterinarians.

13. *Draw and ship blood for testing.* The accredited veterinarian must perform this duty in connection with several APHIS programs, such as export certification of animals.

14. *Perform a caudal fold test for tuberculosis.* This test is a key part of the APHIS tuberculosis program, and is often performed by accredited veterinarians.

15. *Develop appropriate cleaning and disinfection plans to control communicable livestock disease spread.* To control disease spread, cleaning and disinfection of premises where certain communicable animal diseases are found should be done as soon as possible after that discovery. Because an accredited veterinarian is often the first person in authority to identify a disease, he or she should be able to plan

the cleaning and disinfection required by the circumstances.

16. *Explain basic principles for control of diseases for which APHIS programs exist, such as brucellosis, pseudorabies, and tuberculosis.* Accredited veterinarians should be able to explain the methods they use and the requirements they enforce to control these diseases. This should prevent misunderstanding of APHIS programs and explain to persons whose actions are restricted by the regulations why the restrictions are necessary.

Proposed § 161.2(a) would require each applicant for accreditation to:

- (1) Graduate with a Doctorate of Veterinary Medicine or equivalent degree (any degree that qualifies the holder to be licensed by a State to practice veterinary medicine) from a college of veterinary medicine, and
- (2) Attend an orientation program approved by the Veterinarian-in-Charge for the State in which the veterinarian wishes to perform accredited duties.

Attendance at an orientation program would be required as part of the accreditation procedure to ensure sufficient and current knowledge of Federal animal health rules, objectives, and programs by the applicant. The orientation program would include the following topics, listed in proposed § 161.2(a)(4):

1. Federal animal health laws, regulations, and rules;
2. Interstate movement requirements for animals;
3. Import and export requirements for animals;
4. USDA animal disease eradication and control programs;
5. Laboratory support in confirming disease diagnoses;
6. Ethical/Professional responsibilities of an accredited veterinarian; and,
7. Animal health procedures, issues, and information resources relevant to the State in which the veterinarian wishes to perform accredited duties.

By requiring an applicant to certify that he or she can perform the specified tasks, and to complete an orientation in the above topics, APHIS could ensure that applicants for accreditation have been thoroughly instructed in these tasks and topics. We believe that this system is more reliable than a written test, which for practical reasons may assess only limited areas of the necessary skills, for the purpose of ensuring technical competence in accredited veterinarians.

We also propose to revise § 161.2(b), which deals with reaccreditation of veterinarians whose accreditation have been revoked. Formerly, one condition for reaccreditation was that the

applicant must furnish "adequate assurance that he or she will faithfully fulfill the duties of an accredited veterinarian in the future." Because experience has shown that it is difficult to determine what constitutes such "adequate assurance," we propose to revise this provision by dropping the term "adequate assurance" and by adding a new § 161.2(b)(4) requiring that in reaccreditation cases, the Administrator must determine that:

The professional integrity and reputation of the applicant support a conclusion that the applicant will faithfully fulfill the duties of an accredited veterinarian in the future. In making this conclusion, the Administrator may consider:

- (i) Criminal conviction records adversely reflecting on the honesty or integrity of the applicant with regard to the performance or nonperformance of veterinary medical duties;
- (ii) Official records of the applicant's actions participating in Federal, State, or local veterinary programs;
- (iii) Judicial determinations in civil litigation adversely reflecting on the integrity of the applicant; and
- (iv) Any other evidence reflecting on the professional integrity and reputation of the applicant.

Veterinarians whose accreditation has been revoked and who are later reaccredited would also have to complete a reaccreditation orientation, covering topics deemed necessary by the Veterinarian-in-Charge based on the reasons the veterinarian lost accreditation and any changes to procedures for accredited work which have occurred since the veterinarian's accreditation status was revoked. The State Animal Health Official would be given an opportunity to review the content of reaccreditation orientation programs, because we believe these officials may have valuable suggestions on what topics relevant to their State should be included.

In the application processes for both accreditation and reaccreditation, we propose that the Veterinarian-in-Charge who receives the application should give the State Animal Health Official for the State involved the opportunity to review the application and either endorse it or return it with an explanation of why it was not endorsed. One purpose of this endorsement is to have the State Animal Health Official indicate that the applicant is licensed to practice veterinary medicine in the involved State. This endorsement practice would also give State Animal Health Officials the opportunity to present any objections they may have to the accreditation or reaccreditation of applicants. However, the ultimate decision on accreditation or reaccreditation rests with the

Administrator. To keep the process timely, a State Animal Health Official would have only 14 days to endorse an application or present objections to it; after that time, the Veterinarian-in-Charge would proceed with review of the application.

Moving from application procedures into the area of how accredited veterinarians perform their duties, we propose to permit an "authorized assistant" to control certain papers and materials that previously only the accredited veterinarian was able to control. An authorized assistant would be defined as "An individual who is an employee, agent, or business partner of an accredited veterinarian, who is authorized by the accredited veterinarian to perform specified duties or have access to specified materials associated with the performance of the accredited veterinarian's work, and who is named in a written delegation of authority signed by the accredited veterinarian and on file with the Veterinarian-in-Charge of each State in which the assistant is authorized to perform such duties."

In addition to adding this definition of "authorized assistant," we propose to add language to § 161.3 allowing delegations of authority to authorize such assistants to sign documents for the accredited veterinarian, using the format "signed for (name of accredited veterinarian) by (name of authorized assistant)." The delegation of authority would also specify duties the authorized assistant is authorized to perform and materials associated with the performance of the accredited veterinarian's work to which the authorized assistant is allowed access.

The authorized assistant would be authorized to sign for the accredited veterinarian in order to decrease the veterinarian's paperwork burden. The accredited veterinarian would be responsible for the accuracy and completeness of all tests or activities performed including the information on any certificate of form signed by the authorized assistant.

As discussed below under "Miscellaneous changes," we propose to add or modify several definitions in § 160.1. Definitions of two important terms, "inspect" and "examine," would be added. These definitions would read as follows.

Inspect, inspection. Visual study of the physical appearance, physical condition, and behavior of animals (singly or in groups) that enables an accredited veterinarian to determine whether any abnormality in physical condition or bodily function is evident.

When animals are inspected, they are subjected to a lesser degree of scrutiny than during an examination, defined below. Inspection involves visual study to detect abnormalities that should be apparent to an accredited veterinarian. It is important to define this term because inspecting animals is a common duty of accredited veterinarians, and is mentioned throughout § 161.3. "Standards for accredited veterinarian duties." In addition, if an accredited veterinarian performs an inspection improperly, or issues a false or incorrect inspection certificate, he or she would be subject to suspension or revocation of accredited status, or civil and criminal penalties, in accordance with proposed § 161.4.

Examine, examination. Physical study of an animal that enables an accredited veterinarian to determine if any abnormality in physical condition or bodily function is the result of a communicable disease.

Examination is the study of an animal that exceeds the visual study performed during an inspection. Inspection should detect physical abnormalities; examination should determine whether the abnormalities are the result of a communicable disease. Applicants for accredited veterinarian status must certify their ability to perform examinations, in accordance with § 161.2(d). Examining animals is also a common duty of accredited veterinarians, required in § 161.3, and accredited veterinarians who perform examinations improperly would be subject to the penalties discussed above.

We propose several other changes to the standards for accredited veterinarian duties in § 161.3. We propose to delete all references to duties under 9 CFR subchapter A, which concerns the Animal Welfare Act (Pub. L. 89-544, as amended) and the Horse Protection Act (Pub. L. 91-540, as amended). APHIS is no longer employing accredited veterinarians to perform those duties.

We propose to revise § 161.3(a) to require that when issuing a certificate, form, record, or report regarding an animal, the accredited veterinarian must have personally observed the animal within 24 hours of the signing. The current language does not include the 24 hour limit, which we think is necessary to ensure that official documents reflect the current status of animals.

Current § 161.3(c) concerns situations where an accredited veterinarian signs documents reflecting the results of an inspection, test vaccination, or treatment performed by another accredited veterinarian. We propose to

add a requirement that when signing a document for another accredited veterinarian, the signing accredited veterinarian must exercise "reasonable care, that is, a standard of care that a reasonably prudent person would use under the circumstances in the course of performing professional duties, to determine that the certificate, form, or report is accurate."

We propose to change § 161.3(e), which concerns identification of reactor animals by accredited veterinarians, to drop the language that requires the accredited veterinarian to follow identification instructions issued by a State Animal Health Official. We believe that such instructions should be issued by the Veterinarian-in-Charge. We also propose to change this paragraph to allow the accredited veterinarian to either perform the identification of reactor animals or to supervise the identification, since either approach would ensure proper identification of reactor animals.

Current § 161.3(1) (proposed § 161.3(k)) deals with certificates issued by accredited veterinarians for export of animals. Normally such certificates include the results of any laboratory tests required to export the animal. Upon occasion, waiting for pending test results would delay the export schedule for the animal. To avoid this, the regulations allow the accredited veterinarian to issue the certificate without including the test results if a Veterinary Services veterinarian agrees to add the test results to the certificate at a later time. We propose that when such an arrangement is made, the accredited veterinarian must record on the certificate the name of the Veterinary Services veterinarian responsible for adding the test results to the certificate.

A new paragraph 161.4(d) is proposed to identify violations of the regulations that could cause a veterinarian to be subject to civil or criminal penalties, in addition to suspension or revocation of accreditation for violations of the standards for accredited veterinarians. These violations include knowingly issuing a false, incorrect, or mislabeled animal health or inspection certificate, blood sample, official brucellosis vaccination certificate, or official tuberculin or brucellosis test certificate. Pointing out the possibility of penalties should help deter veterinarians from committing these violations, which can damage the American livestock industry and endanger public health.

We also propose to revise Part 162—Rules of Practice Governing Revocation or Suspension of Veterinarians' Accreditation, to clarify the outcomes

that could result from this process. The possible outcomes are:

(1) A letter to the accredited veterinarian dismissing the case after investigation shows that the accredited veterinarian did not violate the standards.

(2) A letter to the accredited veterinarian dismissing the case, but identifying actions of the accredited veterinarian that violate the standards, instructing the accredited veterinarian in proper procedures, and admonishing the accredited veterinarian to use greater care. We believe that such a letter could serve as a useful and appropriate warning for situations where an accredited veterinarian does not repeatedly violate the standards, but repeated administrative errors require more than warning letters. Therefore, we also propose to add language to § 161.12(d) stating that issuance of three or more letters of dismissal citing incidents of administrative errors by an accredited veterinarian may be cause for more severe action, i.e. suspension or revocation of accredited veterinarian status, or civil or criminal penalties where appropriate.

(3) A letter of warning identifying a significant breach of the standards that does not warrant suspension or revocation of accreditation.

(4) Suspension of accreditation; and

(5) Revocation of accreditation.

The Rules of Practice in part 162 allow alleged violations to be dealt with first on the level of an informal conference and then, if the outcome of this stage justifies it, a formal written complaint. The first two outcomes identified above—letters of dismissal—could be generated during or before the informal conference stage. The third possible outcome—a letter of warning—is generally issued at either the informal conference stage or the formal complaint process. The final two outcomes—suspension or revocation—could occur only after a formal complaint is processed, unless the accredited veterinarian consents in writing to such an outcome.

With two exceptions, an informal conference is always held for accredited veterinarians who have been notified in accordance with § 162.11 that there is reason to believe that he or she has not complied with the standards for accredited veterinarians in § 161.3. The two exceptions occur if: The case is dismissed by the Veterinarian-in-Charge before the stage when an informal conference would be held; or, civil or criminal charges are pending against the accredited veterinarian for the same actions or inactions believed to be in violation of the standards for accredited

veterinarians in § 161.3. In this latter instance, an informal conference would be redundant and inappropriate because proceedings would be in progress in accordance with the applicable rules of civil or criminal law. Holding an informal conference at the same time could interfere with the civil or criminal proceedings; therefore, no informal conference would be held until after the civil or criminal charges have been resolved.

We propose that an informal conference shall include the Veterinarian-in-Charge or his or her representative, the accredited veterinarian, and any other persons the Veterinarian-in-Charge requests to attend due to their involvement in or knowledge of the possible violation. The State Animal Health Official would be invited to attend each informal conference held regarding activities in his or her State. At the discretion of the Veterinarian-in-Charge, informal conferences may be held by telephone. We believe these standards for informal conferences would allow alleged violations that do not justify more formal proceeding to be settled efficiently and fairly.

We are proposing these changes to the Rules of Practice in part 162 because the current regulations do not provide for notification to the accredited veterinarian if the case is dismissed, and because the current regulations are unclear regarding the use of informal conferences and letters of warning.

Miscellaneous Charges

We also propose to add or modify definitions of "Accredited veterinarian," "Administrator," "Animal," "Animal and Plant Health Inspection Service," "Examine," "Inspect," "Official certificate, form, record, report, tag, band or other identification," "State animal health official," and "Veterinarian-in-Charge" to make the definitions consistent with their use in the regulations and to aid understanding of the regulations. We also propose to delete references throughout the regulations to duties no longer required of accredited veterinarians concerning the Animal Welfare Act and Horse Protection Act (9 CFR subchapter A), and to make other minor editorial changes to the chapter 9 CFR Subchapter A, and to make other minor editorial changes in the regulations consistent with the changes described above.

Executive Order 12291 and Regulatory Flexibility Act

We are issuing this proposed rule in conformance with Executive Order

12291, and we have determined that it is not a "major rule." Based on information compiled by the Department, it has been determined that this rule, if adopted, would have an effect on the economy of less than \$100 million; would not cause a major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; and would not cause a significant adverse effect on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

This proposed amendment, if adopted, would establish accreditation on a national rather than a State basis, and would also remove a test currently required for accredited veterinarians, require an orientation program for each accredited veterinarian, and specify standards for performance of certain services by accredited veterinarians.

There are currently approximately 45,000 accredited veterinarians practicing in the United States. Approximately 2,000 new accredited veterinarians, mostly recent graduates, are added to the system each year. The degree to which their income depends on performing accredited work varies greatly within this population, and we have little reliable information in this area. It appears that accredited veterinarians may be divided into three groups in terms of the income they derive from performing accredited work. A small minority of accredited veterinarians derive most of their income from accredited work. A large minority of accredited veterinarians derive only a small portion of their income from accredited work. The largest group in the accredited veterinarian population derives a significant but not major portion of their income from accredited work. (Another minor group, irrelevant to economic considerations under the proposed rule, is accredited but receives no income from performing accredited work.)

The proposed changes should not significantly affect the number of accredited veterinarians, the expenses they accrue to become accredited, or the income they derive from performing accredited work. The changes essentially affect application procedures without imposing any significant new application costs.

Under these circumstances, the Administrator of the Animal and Plant Health Inspection Service has determined that this action would not have a significant economic impact on a substantial number of small entities.

Executive Order 12778

This proposed rule has been reviewed under Executive Order 12778, Civil Justice Reform. If this proposed rule is adopted: (1) All State and local laws and regulations that are in conflict with this rule will be preempted; (2) no retroactive effect will be given to this rule; and (3) administrative proceedings are required before the suspension or revocation of a veterinarian's accreditation can be challenged in court.

Executive Order 12372

This program/activity is listed in the Catalog of Federal Domestic Assistance under No. 10.025 and is subject to Executive Order 12372, which requires intergovernmental consultation with State and local officials. (See 7 CFR, part 3015, subpart V).

Paperwork Reduction Act

In accordance with section 3507 of the Paperwork Reduction Act of 1980 (44 U.S.C. chapter 35), the information collection provisions that are included in this proposed rule will be submitted for approval to the Office of Management and Budget (OMB). Your written comments will be considered if you submit them to the Office of Information and Regulatory Affairs, OMB, Attention: Desk Officer for APHIS, Washington, DC 20503. You should submit a duplicate copy of your comments to: (1) Chief, Regulatory Analysis and Development, PPD, APHIS, USDA, room 804, Federal Building, 6505 Belcrest Road, Hyattsville, MD 20782 and (2) Clearance Officer, OIRM, USDA, room 404-W, 14th Street and Independence Avenue, SW., Washington, DC 20250.

List of Subjects in 9 CFR Parts 160, 161, and 162

Administrative practice and procedures, Veterinarians.

Accordingly, we propose to revise subchapter I of 9 CFR chapter 1 to read as follows:

SUBCHAPTER I—ACCREDITATION OF VETERINARIANS AND SUSPENSION OR REVOCATION OF SUCH ACCREDITATION

Parts

- 160 Definition of terms
- 161 Requirements and standards for accredited veterinarians and suspension or revocation of such accreditation
- 162 Rules of practice governing revocation or suspension of veterinarians' accreditation

SUBCHAPTER I—ACCREDITATION OF VETERINARIANS AND SUSPENSION OR REVOCATION OF SUCH ACCREDITATION

PART 160—DEFINITION OF TERMS

§ 160.1 Definitions.

For the purposes of this subchapter the following words, phrases, names and terms shall be construed, respectively, to mean:

Accredited Veterinarian.¹ A veterinarian approved by the Administrator in accordance with the provisions of part 161 of this subchapter to perform functions specified in subchapters B, C, and D of this chapter.

Administrator. The Administrator of the Animal and Plant Health Inspection Service or any individual authorized to act for the Administrator.

Animal, animals. All animals except human, including but not limited to cattle, sheep, goats, other ruminants, swine, horses, asses, mules, zebras, dogs, birds, and poultry.

Animal and Plant Health Inspection Service. The Animal and Plant Health Inspection Service, United States Department of Agriculture.

APHIS. The animal and Plant Health Inspection Service.

Authorized assistant. An individual who is an employee, agent, or business partner of an accredited veterinarian, who is authorized by the accredited veterinarian to perform specified duties or have access to specified materials associated with the performance of the accredited veterinarian's work, and who is named in a written delegation of authority signed by the accredited veterinarian and on file with the Veterinarian-in-Charge of each State in which the assistant is authorized to perform such duties.

Examine, examination. Physical study of an animal that enable an accredited veterinarian to determine if any abnormality in physical condition or bodily function is the result of a communicable disease.

Inspect, inspection. Visual study of the physical appearance, physical condition, and behavior of animals (singly or in groups) that enables an accredited veterinarian to determine whether any abnormality in physical condition or bodily function is evident.

¹ The provisions of subchapters B, C, and D of this chapter authorize Federal and State veterinarians and accredited veterinarians to perform specified functions. Full-time Federal (including military) and State employed veterinarians are authorized to perform such functions, pursuant to delegation of authority by the Administrator or cooperative agreements without specific accreditation under the provisions of this subchapter.

Official certificate, form, record, report, tag, band, or other identification. Means any certificate, form, record, report, tag, band, or other identification, prescribed by statute or by regulations issued by the Administrator, for use by an accredited veterinarian performing official functions under this subchapter.

State. Any State, the District of Columbia, Puerto Rico, Guam, the Northern Mariana Islands, the Virgin Islands of the United States, and any other territory or possession of the United States.

State Animal Health Official. The State animal health official who is responsible for the livestock and poultry disease control and eradication programs of a State.

Veterinarian-in-Charge. The veterinary official of APHIS who is assigned by the Administrator to supervise and perform the official work of APHIS in a State or group of States.

Authority: 15 U.S.C. 1828; 21 U.S.C. 105, 111-114, 114a, 114a-1, 115, 116, 120, 121, 125, 134b, 134f, 612, and 613; 7 CFR 2.17, 2.51, and 371.2(d).

PART 161—REQUIREMENTS AND STANDARDS FOR ACCREDITED VETERINARIANS AND SUSPENSION OR REVOCATION OF SUCH ACCREDITATION

Sec.

- 161.1 Statement of purpose; performance of accredited duties in different States.
- 161.2 Requirements and application procedures for accreditation.
- 161.3 Standards for accredited veterinarian duties.
- 161.4 Suspension or revocation of veterinary accreditation; criminal and civil penalties.

Authority: 15 U.S.C. 1828; 21 U.S.C. 105, 111-114, 114a, 114a-1, 115, 116, 120, 121, 125, 134b, 134f, 612, and 613; 7 CFR 2.17, 2.51, and 371.2(d).

§ 161.1 Statement of purpose; performance of accredited duties in different States.

(a) This subchapter concerns a program administered by APHIS to accredit veterinarians and thereby authorize them to perform, on behalf of APHIS, certain activities specified in this chapter. This program is intended to ensure that an adequate number of qualified veterinarians are available in the United States to perform such activities.

(b) If an accredited veterinarian wishes to perform accredited duties in a State other than the State for which the veterinarian has completed an orientation in accordance with § 161.2(a)(4), the accredited veterinarian shall so inform the Veterinarian-in-Charge of the new State.

The Veterinarian-in-Charge of the new State may require the accredited veterinarian to complete, prior to performing any accredited duties in the new State, an orientation in animal health procedures and issues relevant to the new State. The Veterinarian-in-Charge shall review the content of each such orientation and shall approve its use after determining that it includes adequate information about animal health agencies, regulatory requirements, administrative procedures, and animal disease problems in the new State, to prepare an accredited veterinarian from another State to perform accredited duties in the new State. The Veterinarian-in-Charge shall also give the State Animal Health Official of the new State an opportunity to review the contents of the orientation.

§ 161.2 Requirements and application procedures for accrediting

(a) *Initial Accreditation.* A veterinarian may apply for accreditation by completing an application for accreditation on Form 1-36A, "Application for Veterinary Accreditation," including certification that the applicant is able to perform the tasks listed in paragraph (d) of this section, and submitting it to a Veterinarian-in-Charge.

(1) Completed Forms 1-36A received by a Veterinarian-in-Charge shall be reviewed by the State Animal Health Official¹ for the State in which the veterinarian wishes to perform accredited duties. Within 14 days after receiving an application, a State Animal Health Official shall either endorse the application or send a written statement to the Administrator explaining why it was not endorsed; but if the State Animal Health Official fails to take one of these actions within 14 days, the Veterinarian-in-Charge shall proceed to review the application. The Administrator will review the application and the written statement, if any, and determine whether the applicant meets the requirements for accreditation contained in this part.

(2) The Administrator is hereby authorized to accredit a veterinarian when he or she determines that:

(i) The veterinarian is a graduate with a Doctorate of Veterinary Medicine or an equivalent degree (any degree that qualifies the holder to be licensed by a State to practice veterinary medicine) from a college of veterinary medicine;

¹ Endorsement by the State Animal Health Official shall also indicate that the applicant is licensed to practice veterinary medicine in the State for which the State Animal Health Official is responsible.

(ii) The veterinarian is licensed to practice veterinary medicine in the State in which the veterinarian wishes to perform accredited duties; and,

(iii) The veterinarian has completed an orientation program approved by the Veterinarian-in-Charge² for the State in which the veterinarian wishes to practice, and upon completion of the orientation, has signed a written statement listing the data and place or orientation, the subjects covered in the orientation, and any written materials provided to the veterinarian at the orientation. The orientation program shall include the following topics.

(A) Federal animal health laws, regulations, and rules;

(B) Interstate movement requirements for animals;

(C) Import and export requirements for animals.

(D) USDA animal disease eradication and control programs;

(E) Laboratory support in conforming disease diagnoses;

(F) Ethical/Professional responsibilities of an accredited veterinarian; and,

(G) Animal health procedures, issues, and information resources relevant to the State in which the veterinarian wishes to perform accredited duties.

(b) *Reaccreditation.* A veterinarian whose accreditation has been revoked may apply for reaccreditation when the revocation has been in effect for not less than two years by completing an application for reaccreditation on Form 1-36A, "Application for Veterinary Accreditation", and submitting it to the Veterinarian-in-Charge of the State or area where he or she wishes to perform accredited work.

(1) Completed Forms 1-36A received by a Veterinarian-in-Charge shall be reviewed by the State Animal Health Official³ for the State in which the veterinarian wishes to perform accredited duties. Within 14 days after receiving an application, a State Animal Health Official shall either endorse the application or send a written statement to the Administrator explaining why it was not endorsed; but if the State Animal Health Official fails to take one of these actions within 14 days, the Veterinarian-in-Charge shall proceed to review the application. The Administrator will review the

² The State Animal Health Official shall be given an opportunity to review the content of orientation programs.

³ Endorsement by the State Animal Health Official shall also indicate that the applicant is licensed to practice veterinary medicine in the State for which the State Animal Health Official is responsible.

application and the written statement, if any, and determine whether the applicant meets the requirements for reaccreditation contained in this part.

(2) The Administrator is hereby authorized to reaccredit a veterinarian when he or she determines that:

(i) The veterinarian is licensed to practice veterinary medicine in the State in which the veterinarian wishes to perform accredited duties;

(ii) The veterinarian has completed a reaccreditation orientation program approved by the Veterinarian-in-Charge for the State in which the veterinarian wishes to practice, and upon completion of the orientation, has signed a written statement listing the date and place of orientation, the subjects covered in the orientation, and any written materials provided to the veterinarian at the orientation. The orientation program shall include topics addressing the subject areas which led to loss of accreditation for the applicant, and subject areas which have changed since the applicant lost accreditation;⁴ and,

(iii) The professional integrity and reputation of the applicant support a conclusion that the applicant will faithfully fulfill the duties of an accredited veterinarian in the future. In making this conclusion, the Administrator shall consider:

(A) Criminal conviction records adversely reflecting on the honesty or integrity of the applicant with regard to the performance or nonperformance of veterinary medical duties;

(B) Official records of the applicant's actions participating in Federal, State, or local veterinary programs;

(C) Judicial determinations in civil litigation adversely reflecting on the integrity of the applicant; and

(D) Any other evidence reflecting on the professional integrity and reputation of the applicant.

(c) *Reinstatement after suspension.* A veterinarian whose accreditation has been suspended (other than a summary suspension that is changed to a revocation as the result of an adjudicatory proceeding) will be automatically reinstated as an accredited veterinarian upon completion of the suspension.

(d) *Tasks which applicants for accredited status must be able to perform.* Applicants for accredited status must be able to:

(1) Perform physical examinations of individual animals, herds, or flocks to

determine whether they are free from communicable diseases;

(2) Recognize the common breeds of livestock so as to be able to record breed information on official documents;

(3) Recognize brucellosis tattoos and calfhood vaccination tags, and determine the State of origin of eartags, to properly identify animals in interstate commerce;

(4) Estimate the age of livestock using dental formula;

(5) Apply an eartag, tattoo, backtag, and legband;

(6) Certify the disease status of a poultry flock with regard to disease caused by *Salmonella enteritidis*, psittacosis, and velogenic viscerotropic Newcastle disease;

(7) Properly complete certificates for domestic and international movement of animals;

(8) Apply and remove official seals;

(9) Perform a necropsy on livestock;

(10) Recognize signs and lesions of exotic animal diseases;

(11) Plan a disease control strategy for a livestock unit;

(12) Vaccinate for brucellosis and fill out the vaccination certificate;

(13) Draw and ship blood for testing;

(14) Perform a caudal fold test for tuberculosis;

(15) Develop appropriate cleaning and disinfection plans to control communicable livestock disease spread; and

(16) Explain basic principles for control of diseases for which APHIS programs exist, such as brucellosis, pseudorabies, and tuberculosis.

(Approved by the Office of Management and Budget under control number 0579-0032)

§ 161.3 Standards for accredited veterinarian duties.

An accredited veterinarian shall perform the functions of accredited veterinarian only in a State in which the accredited veterinarian is licensed. An authorized assistant may be authorized to perform specified duties or have access to specified materials associated with the performance of an accredited veterinarian's work, if the authorized assistant is named in a written delegation of authority signed by the accredited veterinarian and on file with the Veterinarian-in-Charge. The delegation of authority shall also specify duties the authorized assistant is authorized to perform and materials associated with the performance of the accredited veterinarian's work to which the authorized assistant is allowed access. The delegation of authority may also authorize an authorized assistant to sign documents for the accredited veterinarian, using the format "signed

for (name of accredited veterinarian) by (name of authorized assistant)." The accredited veterinarian will be responsible for the accuracy and completeness of all tests of activities performed by their authorized assistant, including the accuracy and completeness of the information on any official certificate, form, record or report signed by the authorized assistant. An accredited veterinarian shall perform the functions of an accredited veterinarian and carry out all responsibilities under the applicable Federal programs and cooperative programs subject to direction provided by the Veterinarian-in-Charge and in accordance with any regulations and instructions issued to the accredited veterinarian by the Veterinarian-in-Charge, and shall observe the following specific standards:

(a) An accredited veterinarian shall not issue or sign a certificate, form, record or report which reflects the result of any inspection, test, vaccination or treatment performed by him or her, with respect to any animal, unless he or she, within 24 hours prior to such signing, has personally observed each animal in a location that allows the accredited veterinarian sufficient space to observe the animal in such a manner as to detect abnormalities related to areas such as, but not limited to, locomotion, body excretion, respiration, and skin conditions. An accredited veterinarian shall examine each animal showing abnormalities, in order to determine whether or not there is visible evidence of the presence or absence of a communicable disease.

(b) An accredited veterinarian shall not issue or sign any certificate, form, record or report to be used until, and unless, it has been accurately and fully completed, clearly identifying the animals to which it applies, and showing the dates and results of any inspection, test, or vaccination the accredited veterinarian has conducted, except as provided in paragraph (c) of this section. The accredited veterinarian shall distribute copies of certificates, forms, records and reports, according to instructions issued to instruction issued to him or her by the Veterinarian-in-Charge.

(c) An accredited veterinarian shall not issue or sign any certificate, form, record or report which reflects the results of any inspection, test, vaccination, or treatment, performed by another accredited veterinarian, unless:

(1) The signing accredited veterinarian has exercised reasonable care, that is, a standard of care that a reasonable prudent person would use under the

⁴ The State Animal Health Official shall be given an opportunity to review the content of reaccreditation orientation programs.

circumstances in the course of performing professional duties, to determine that the certificate, form, or report is accurate;

(2) The certificate, form or report indicates that the inspection, test, vaccination, or treatment was performed by the other accredited veterinarian; identifies the other veterinarian by name; and includes the date and the place where such inspection, test, or vaccination was performed; and,

(3) For a certificate, form, or report indicating results of a laboratory test, the signing accredited veterinarian shall keep a copy of the certificate, form, or report and shall attach to it either a copy of the test results issued by the laboratory, or a written record (including date and participant's names) of a conversation between the signing accredited veterinarian and the laboratory confirming the test results.

(d) An accredited veterinarian shall perform official tests, inspections, treatments, and vaccinations and shall submit specimens to designated laboratories in accordance with Federal and State regulations and instructions issued to the accredited veterinarian by the Veterinarian-in-Charge.

(e) An accredited veterinarian shall identify or supervise the identification of reactor animals by tagging or such other method as may be prescribed in instructions issued to him or her by the Veterinarian-in-Charge.

(f) An accredited veterinarian shall immediately report to the Veterinarian-in-Charge all diagnosed or suspected cases of a communicable animal disease for which APHIS has a control or eradication program in 9 CFR chapter I, and all diagnosed or suspected cases of any animal disease not known to exist in the United States as provided by § 71.3(b) of this chapter.

(g) While performing accredited work, an accredited veterinarian shall take such measures of sanitation as are necessary to prevent the spread of communicable diseases of animals by the accredited veterinarian.

(h) An accredited veterinarian shall keep himself or herself currently informed on Federal and State regulations that are provided to him or her by the Veterinarian-in-Charge, or by the State official through the Veterinarian-in-Charge, governing the movement of animals, and on procedures applicable to disease control and eradication programs, including emergency programs.

(i) An accredited veterinarian shall not use or dispense in any manner, any pharmaceutical, chemical, vaccine or serum, or other biological product authorized for use under any Federal

regulation or cooperative disease eradication program, in contravention of any Federal and State statute or regulation, or instruction issued to the accredited veterinarian by the Veterinarian-in-Charge.

(j) An accredited veterinarian shall be responsible for the security and proper use of all official certificates, forms, records, reports, tags, bands, or other identification devices used in his or her work as an accredited veterinarian and shall take reasonable care to prevent misuse thereof. An accredited veterinarian shall immediately report to the Veterinarian-in-Charge, the loss, theft, or deliberate or accidental misuse of any such certificate, form, record, report, tag, band, or other identification devices.

(k) An accredited veterinarian may issue or sign an original health certificate for export use pursuant to part 91 of this Chapter without including tests results from a laboratory, if a Veterinary Services veterinarian has determined that action is necessary to save time in order to meet an exportation schedule and agrees to add the tests to the certificate at a later time. In such cases, the accredited veterinarian shall state on the certificate that such test results are to be added by the Veterinary Services veterinarian and shall state on the certificate the name of the Veterinary Services veterinarian.

§ 161.4 Suspension or revocation of veterinary accreditation; criminal and civil penalties.

(a) The Administrator is authorized to suspend for a given period of time, or to revoke, the accreditation of a veterinarian when he or she determines that the accredited veterinarian has not complied with the "Standards for Accredited Veterinarians" as set forth in § 161.3, or, in lieu thereof, to issue a written notice of warning to the accredited veterinarian when the Administrator determines a notice of warning will be adequate to attain compliance with the Standards.

(b) Accreditation shall be automatically terminated when an accredited veterinarian is not licensed to practice veterinary medicine in at least one State.

(c) Accreditation shall be automatically revoked when an accredited veterinarian is convicted for a crime in either State or Federal court, if such conviction is based on the performance or nonperformance of any act required of him or her in his capacity as an accredited veterinarian.

(d) Any accredited veterinarian who knowingly issues or signs a false, incorrect, or mislabeled animal health or

inspection certificate, blood sample, official brucellosis vaccination certificate, or official tuberculin test certificate in accordance with this chapter, shall be subject to such civil penalties and such criminal liabilities as are provided by 18 U.S.C. 1001, 21 U.S.C. 117, 122, 127, and 134e, or other applicable Federal statutes. Such action may be in addition to, or in lieu of, suspension or revocation of accredited veterinarian status in accordance with § 161.4 of this chapter.

PART 162—RULES OF PRACTICE GOVERNING REVOCATION OR SUSPENSION OF VETERINARIANS' ACCREDITATION

Subpart A—General

Sec.

162.1 Scope and applicability of rules of practice.

Subpart B—Supplemental Rules of Practice

162.10 Summary suspension of accreditation of veterinarian.

162.11 Notification.

162.12 Informal conference.

162.13 Formal complaint.

Authority: 15 U.S.C. 1828; 21 U.S.C. 105, 111–114, 114a, 114a–1, 115, 116, 120, 121, 125, 134b, 134f, 612, and 613; 7 CFR 2.17, 2.51, and 371.2(d).

Subpart A—General

§ 162.1 Scope and applicability of rules of practice.

The Uniform Rules of Practice for the Department of Agriculture promulgated in subpart H of part 1, subtitle A, title 7, Code of Federal Regulations, are the Rules of Practice applicable to adjudicatory, administrative proceedings for the revocation or suspension of accreditation of veterinarians (9 CFR parts 160 and 161). In addition, the Supplemental Rules of Practice set forth in Subpart B of this part shall be applicable to such proceedings.

Subpart B—Supplemental Rules of Practice

§ 162.10 Summary suspension of accreditation of veterinarians.

In any situation where the Administrator has reason to believe that any veterinarian accredited under the provisions of 9 CFR parts 160 and 161 has not complied with the "Standards for Accredited Veterinarians" set forth in § 161.3 of this chapter, and deems such action necessary in order to prevent the introduction into the United States or the spread from one State to another of a contagious, infectious, or communicable disease of animals, or to

insure that animals intended or offered for export to foreign countries are free from disease, the Administrator may suspend the accreditation of such veterinarian pending final determination in the proceeding, effective upon oral or written notification, whichever is earlier. In the event of oral notification, a written confirmation thereof shall be given to such veterinarian pursuant to § 1.147(b) of the Uniform Rules of Practice (7 CFR 1.147(b)) as promptly as circumstances permit. Such suspension shall have no relevance with respect to the final determination in the proceeding.

§ 162.11 Notification.

The Veterinarian-in-Charge shall notify an accredited veterinarian when there is reason to believe that the accredited veterinarian has not complied with the "Standards for Accredited Veterinarians" as contained in § 161.3 of this chapter. The notification shall be in writing, with a copy to the State Animal Health Official, and shall include a statement of the basis for the belief that the accredited veterinarian has failed to comply with the standards and shall notify the accredited veterinarian if the Veterinarian-in-Charge has arranged to hold an informal conference to discuss the matter.

§ 162.12 Informal conference.

(a) The Veterinarian-in-Charge, in consultation with the State Animal Health Official and the accredited veterinarian, shall designate the time and place for the holding of an informal conference to review the matter, unless the Veterinarian-in-Charge determines that an informal conference is not appropriate. An informal conference is not appropriate only in the Veterinarian-in-Charge decides to dismiss the case based on available facts, or if civil or criminal charges based on the actions or inactions believed to be in violation of the "Standards for Accredited Veterinarians" contained in § 161.3 of this chapter are pending against the accredited veterinarian. An informal conference shall include the Veterinarian-in-Charge or his or her representative, the accredited veterinarian, and any other persons the Veterinarian-in-Charge requests to attend due to their involvement in or knowledge of the possible violation. The State Animal Health Official will be invited to attend each informal conference held regarding activities in his or her State. At the discretion of the

Veterinarian-in-Charge, informal conferences may be held by telephone.

(b) Prior to, during, or at the conclusion of the informal conference, the Veterinarian-in-Charge may issue a written warning to the accredited veterinarian without further procedure after determining that a warning with appropriate instructions will be adequate to attain compliance with the standards.

(c) If prior to, during, or at the conclusion of, the informal conference, the accredited veterinarian consents, in writing, to the issuance of an order revoking or suspending his or her accreditation for a specified period of time, in lieu of further procedure, the Veterinarian-in-Charge may issue such a consent order without further procedure.

(d) If prior to, during, or after the informal conference, but prior to the issuance of a formal complaint, the accredited veterinarian is found not to have violated the regulations, the Veterinarian-in-Charge will issue a letter dismissing the case, and provide a copy of the letter to the accredited veterinarian and to the State Animal Health Official. Prior to, during, or after the informal conference, the Veterinarian-in-Charge may issue a letter identifying actions of the accredited veterinarian that were minor violations of the standards, instructing the accredited veterinarian in proper procedures, and admonishing the accredited veterinarian to use greater care in performing these procedures in the future. Issuance of three or more letters of dismissal citing incidents of minor violations by an accredited veterinarian may be cause for more severe action under this section and § 161.4.

§ 162.13 Formal complaint.

If a consent order has not been issued, or if, after an informal conference, the Veterinarian-in-Charge has not issued a letter of dismissal or letter of warning to the accredited veterinarian, a formal complaint may be issued by the Administrator in accordance with § 1.135 of the Uniform Rules of Practice (7 CFR 1.135).

Done in Washington, DC, this 1st day of June, 1992.

Robert Melland,

Administrator, Animal and Plant Health Inspection Service.

[FR Doc. 92-13068 Filed 6-3-92; 8:45 am]

BILLING CODE 3410-34-M

NUCLEAR REGULATORY COMMISSION

10 CFR Part 100

Revision of Appendix A

AGENCY: Nuclear Regulatory Commission.

ACTION: Notice of meeting.

SUMMARY: The Nuclear Regulatory Commission staff will meet with the staff of the Nuclear Management and Resources Council (NUMARC) and other industry representatives to discuss the revision of Appendix A, "Seismic and Geologic Siting Criteria for Nuclear Power Plants," to 10 CFR part 100.

DATES: June 17, 1992, 1 p.m.

ADDRESSES: 11555 Rockville Pike, Room: 1F7/9, Rockville, Maryland.

FOR FURTHER INFORMATION CONTACT: Dr. Andrew J. Murphy, Chief, Structural and Seismic Engineering Branch, Office of Nuclear Regulatory Research, Nuclear Regulatory Commission, Washington, DC 20555. Telephone: (301) 492-3860.

SUPPLEMENTARY INFORMATION:

Appendix A to 10 CFR part 100 describes the seismic and geologic siting and earthquake engineering criteria for nuclear power plants. Because of the advances in the state-of-the-art since the publication of the regulation (effective December 13, 1973), a need for the revision has been established. Staff progress in the revision of appendix A to 10 CFR part 100 has been discussed in public meetings with NUMARC and other industry representatives on February 4, 1992 and April 23, 1992, the Advisory Committee on Reactor Safeguards, Subcommittee on Extreme External Phenomena on February 5, 1992 and the Advisory Committee on Reactor Safeguards, Full Committee on February 7, 1992.

The purpose of this meeting is to meet with NUMARC and other industry representatives to discuss industry recommended alternatives to the draft proposed revision of appendix A to 10 CFR part 100 that was placed in the NRC Public Document Room at 2120 L Street NW. (Lower Level), Washington, DC (Memorandum from Lawrence C. Shao to Raymond F. Fraley, dated January 21, 1992, Subject: Revision of appendix A to 10 CFR part 100—Geological and Seismological Siting Criteria for Nuclear Power Plants). No specific agenda is being proposed.

Dated at Rockville, Maryland, this 28 day of May, 1992, for the Nuclear Regulatory Commission.

Lawrence C. Shao,

Director, Division of Engineering, Office of Nuclear Regulatory Research.

[FR Doc. 92-13062 Filed 6-3-92; 8:45 am]

BILLING CODE 7590-01-M

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. 92-NM-85-AD]

Airworthiness Directives; Boeing Model 757 Series Airplanes

AGENCY: Federal Aviation Administration, DOT.

ACTION: Notice of proposed rulemaking (NPRM).

SUMMARY: This notice proposes the superseding of an existing airworthiness directive (AD), applicable to certain Boeing Model 757 series airplanes, that currently requires visual inspections of the internal and external splines of the trailing edge flap drive torque tube coupling assembly for excessive wear, and replacement of the coupling, if necessary. That action was prompted by reports of excessive wear on the aft end of the trailing edge flap drive torque tube coupling. This action would add an optional modification that, if installed, would constitute terminating action for the existing inspection requirements. The actions specified by the proposed AD are intended to prevent damage caused by skewed flaps resulting from excessive wear of the splines of the trailing edge flap drive torque tube coupling.

DATES: Comments must be received by July 13, 1992.

ADDRESSES: Submit comments in triplicate to the Federal Aviation Administration (FAA), Transport Airplane Directorate, ANM-103, Attention: Rules Docket No. 92-NM-85-AD, 1601 Lind Avenue SW., Renton, Washington 98055-4056. Comments may be inspected at this location between 9 a.m. and 3 p.m., Monday through Friday, except Federal holidays.

The service information referenced in the proposed rule may be obtained from Boeing Commercial Airplane Group, P.O. Box 3707, Seattle, Washington 98124. This information may be examined at the FAA, Transport Airplane Directorate, 1601 Lind Avenue SW., Renton, Washington.

FOR FURTHER INFORMATION CONTACT:

Ms. Carrie Sumner, Seattle Aircraft Certification Office, Airframe Branch, ANM-120S, FAA, Transport Airplane Directorate, 1601 Lind Avenue SW., Renton, Washington 98055-4056; telephone (206) 227-2778; fax (206) 227-1181.

SUPPLEMENTARY INFORMATION:

Comments Invited

Interested persons are invited to participate in the making of the proposed rule by submitting such written data, views, or arguments as they may desire. Communications shall identify the Rules Docket number and be submitted in triplicate to the address specified above. All communications received on or before the closing date for comments, specified above, will be considered before taking action on the proposed rule. The proposals contained in this notice may be changed in light of the comments received.

Comments are specifically invited on the overall regulatory, economic, environmental, and energy aspects of the proposed rule. All comments submitted will be available, both before and after the closing date for comments, in the Rules Docket for examination by interested persons. A report summarizing each FAA-public contact concerned with the substance of this proposal will be filed in the Rules Docket.

Commenters wishing the FAA to acknowledge receipt of their comments submitted in response to this notice must submit a self-addressed, stamped postcard on which the following statement is made: "Comments to Docket Number 92-NM-85-AD." The postcard will be date stamped and returned to the commenter.

Availability of NPRMs

Any person may obtain a copy of this NPRM by submitting a request to the FAA, Transport Airplane Directorate, ANM-103, Attention: Rules Docket No. 92-NM-85-AD, 1601 Lind Avenue SW., Renton, Washington 98055-4056.

Discussion

On April 4, 1990, the FAA issued AD 90-08-16, Amendment 39-6574 (55 FR 13755, April 12, 1990), to require visual inspections of the internal and external splines of the trailing edge flap drive torque tube coupling assembly for excessive wear, and replacement of the coupling, if necessary. That action was prompted by reports of excessive wear on the aft end of the trailing edge flap drive torque tube coupling. The requirements of that AD are intended to prevent damage caused by skewed flaps

resulting from excessive wear of the splines of the trailing edge flap drive torque tube coupling.

Since the issuance of that AD, the manufacturer has developed a modification that, once installed, would eliminate the need for the inspection requirements of the existing rule.

The FAA has reviewed and approved Boeing Service Bulletin 757-27-0099, dated March 12, 1992, that describes procedures for removing two of the currently installed torque tube assemblies for the trailing edge flaps and replacing them with improved torque tube assemblies part number 251N4281-20 (one on each wing). The service bulletin also describes procedures for installing a sealant plug in the shafts of the four gear boxes. Installation of the improved torque tube assembly and sealant plug eliminates the need for repetitive inspections of the assemblies. The effectivity listing of the service bulletin is limited to certain airplanes having specific line numbers; airplanes not included in this listing were modified in production to include the improved torque tube assemblies and sealant plugs.

The FAA has also reviewed and approved Boeing Service Letter 757-SL-27-52-B, dated April 30, 1990, which describes procedures for visual inspection of the trailing edge flap drive torque tube coupling for excessive wear, and replacement of the coupling, if necessary. This revision contains essentially the identical information as contained in Revision A of this service letter (cited incorrectly as Revision 1 in the superseded rule), but includes new information about AD 90-08-16.

Since an unsafe condition has been identified that is likely to exist or develop on other products of this same type design, the proposed AD would supersede AD 90-08-16 to continue the requirement for inspections of the torque tube coupling assembly, but would add an optional modification (consisting of the installation of improved torque tube assemblies and sealant plugs) that, if installed, would constitute terminating action for the inspections. The optional terminating action would be required to be accomplished in accordance with the Boeing service bulletin described previously.

The applicability of the proposed rule has been revised to exclude those airplanes on which the terminating modification was previously installed during production.

The new revision of the Boeing service letter, described above, is cited in paragraph (a) of this proposal as an

additional source of appropriate service information.

There are approximately 431 Boeing Model 757-series airplanes of the affected design in the worldwide fleet. The FAA estimates that 279 airplanes of U.S. registry would be affected by this proposed AD. The (currently required) inspections necessitate 1.5 work hours to accomplish, at an average labor rate is \$55 per work hour. Based on these figures the total cost impact of the currently required inspections on U.S. operators is \$23,018.

Should an operator elect to install the optional terminating modification, it would take approximately 9 work hours per airplane to accomplish, at an average labor rate of \$55 per work hour. Modification parts would cost approximately \$1,486 per airplane. Based on these figures, the total cost associated with installation of the proposed optional terminating modification is estimated to be \$1,981 per airplane.

The regulations proposed herein would not have substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government. Therefore, in accordance with Executive Order 12612, it is determined that this proposal would not have sufficient federalism implications to warrant the preparation of a Federalism Assessment.

For the reasons discussed above, I certify that this proposed regulation (1) is not a "major rule" under Executive Order 12291; (2) is not a "significant rule" under the DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and (3) if promulgated, will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act. A copy of the draft regulatory evaluation prepared for this action is contained in the Rules Docket. A copy of it may be obtained by contacting the Rules Docket at the location provided under the caption "ADDRESSES."

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Safety.

The Proposed Amendment

Accordingly, pursuant to the authority delegated to me by the Administrator, the Federal Aviation Administration proposes to amend 14 CFR part 39 of the Federal Aviation Regulations as follows:

PART 39—AIRWORTHINESS DIRECTIVES

1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 1354(a), 1421 and 1423; 49 U.S.C. 106(g); and 14 CFR 11.89.

§ 39.13 [Amended]

2. Section 39.13 is amended by removing amendment 39-6574 (55 FR 13755, April 12, 1990), and by adding a new airworthiness directive (AD), to read as follows:

Boeing: Docket 92-NM-85-AD. Supersedes AD 90-08-16, Amendment 39-6574.

Applicability: Model 757 series airplanes; line numbers 1 through 411, inclusive, and 413 through 432, inclusive; certificated in any category.

Compliance: Required as indicated, unless accomplished previously.

To prevent damage caused by skewed flaps resulting from excessive wear of the splines of the trailing edge flap drive torque tube coupling, accomplish the following:

(a) Prior to the accumulation of 2,000 flight cycles, or within the next 200 flight cycles after April 30, 1990, (the effective date of AD 90-08-16), whichever occurs later, and thereafter at intervals not to exceed 2,000 flight cycles, perform an inspection of the torque tube coupling splines, in accordance with Boeing Service Letter 757-SL-27-52, dated January 31, 1990; or Boeing Service Letter 757-SL-27-52-A (Revision 1), dated March 21, 1990; or Boeing Service Letter 757-SL-27-52-B, dated April 30, 1990.

(1) If the measurement over the pin, as detailed in the service letter, is less than 1.8605 inches but equal to or greater than 1.8533 inches, repeat the inspection prior to the accumulation of 1,000 additional flight cycles.

(2) If the measurement over the pin, as detailed in the service letter, is less than 1.8533 inches, replace the coupling prior to further flight, in accordance with the service letters.

(b) Replacement of the torque tube assemblies edge flaps with improved torque tube assemblies, part number 251N4281-20 (one on each wing), and installation of a sealant plug in the shafts of the four gearboxes, in accordance with Boeing Service Bulletin 757-27-0099, dated March 12, 1992, constitutes terminating action for the inspections required by paragraph (a) of this AD.

(c) An alternative method of compliance or adjustment of the compliance time, which provides an acceptable level of safety, may be used when approved by the Manager, Seattle Aircraft Certification Office (ACO), FAA, Transport Airplane Directorate. The request shall be forwarded through an FAA Principal Maintenance Inspector, who may concur or comment and then send it to the Manager, Seattle ACO.

Note: Information concerning the existence of approved alternative methods of compliance with this airworthiness directive, if any, may be obtained from the Seattle ACO.

(d) Special flight permits may be issued in accordance with FAR 21.197 and 21.199 to operate the airplane to a location where the requirements of this AD can be accomplished.

Issued in Renton, Washington, on May 12, 1992.

Darrell M. Pederson,

Acting Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. 92-13046 Filed 6-3-92; 8:45 am]

BILLING CODE 4910-13-M

14 CFR Part 39

[Docket No. 92-NM-64-AD]

Airworthiness Directives; British Aerospace Model BAe 125-600A, -700A, and -800A Series Airplanes

AGENCY: Federal Aviation Administration, DOT.

ACTION: Notice of proposed rulemaking (NPRM).

SUMMARY: This notice proposes the adoption of a new airworthiness directive (AD) that is applicable to certain British Aerospace Model BAe 125-600A, -700A, and -800A series airplanes. This proposal would require modification of the cabin and toilet fluorescent lighting systems. This proposal is prompted by a report that faults in certain cabin and toilet fluorescent lighting systems could cause overheating of components and wiring. The actions specified by the proposed AD are intended to prevent electrical arcing, which can result in a fire.

DATES: Comments must be received by June 29, 1992.

ADDRESSES: Submit comments in triplicate to the Federal Aviation Administration (FAA), Transport Airplane Directorate, ANM-103, Attention: Rules Docket No. 92-NM-64-AD, 1601 Lind Avenue SW., Renton, Washington 98055-4056. Comments may be inspected at this location between 9 a.m. and 3 p.m., Monday through Friday, except Federal holidays.

The service information referenced in the proposed rule may be obtained from British Aerospace, PLC, Librarian for Service Bulletins, P.O. Box 17414, Dulles International Airport, Washington, DC 20041-0414. This information may be examined at the FAA, Transport Airplane Directorate, 1601 Lind Avenue SW., Renton, Washington.

FOR FURTHER INFORMATION CONTACT: Mr. Hank Jenkins, Aerospace Engineer, Standardization Branch, ANM-113, FAA, Transport Airplane Directorate, 1601 Lind Avenue SW., Renton,

Washington 98055-4056; telephone (206) 227-2141; fax (206) 227-1320.

SUPPLEMENTARY INFORMATION:

Comments Invited

Interested persons are invited to participate in the making of the proposed rule by submitting such written data, views, or arguments as they may desire. Communications shall identify the Rules Docket number and be submitted in triplicate to the address specified above. All communications received on or before the closing date for comments, specified above, will be considered before taking action on the proposed rule. The proposals contained in this notice may be changed in light of the comments received.

Comments are specifically invited on the overall regulatory, economic, environmental, and energy aspects of the proposed rule. All comments submitted will be available, both before and after the closing date for comments, in the Rules Docket for examination by interested persons. A report summarizing each FAA-public contact concerned with the substance of this proposal will be filed in the Rules Docket.

Commenters wishing the FAA to acknowledge receipt of their comments submitted in response to this notice must submit a self-addressed, stamped postcard on which the following statement is made: "Comments to Docket Number 92-NM-64-AD." The postcard will be date stamped and returned to the commenter.

Availability of NPRMs

Any person may obtain a copy of this NPRM by submitting a request to the FAA, Transport Airplane Directorate, ANM-103, Attention: Rules Docket No. 92-NM-64-AD, 1601 Lind Avenue SW., Renton, Washington 98055-4056.

Discussion: The United Kingdom Civil Aviation Authority (CAA), which is the airworthiness authority for the United Kingdom, recently notified the FAA that an unsafe condition may exist on certain British Aerospace Model BAe 125-600A, -700A, and -800A series airplanes. The CAA advises that there has been a report that faults in certain cabin and toilet fluorescent lighting systems could cause overheating of components and wiring. This condition, if not corrected, could result in electrical arcing, which can result in a fire.

British Aerospace has issued Service Bulletin 33-45-25A027A&B, dated December 23, 1991, which describes procedures for modification of the cabin and toilet fluorescent lighting systems. This modification consists of replacing the original power units with power

units having integral fault monitoring circuits. Installation of this modification will provide protection against faults that could cause overheating of components and wiring. The CAA classified this service bulletin as mandatory.

This airplane model is manufactured in the United Kingdom and is type certificated for operation in the United States under the provisions of § 21.29 of the Federal Aviation Regulations and the applicable bilateral airworthiness agreement. Pursuant to this bilateral airworthiness agreement, the CAA has kept the FAA informed of the situation described above. The FAA has examined the findings of the CAA, reviewed all available information, and determined that AD action is necessary for products of this type design that are certificated for operation in the United States.

Since an unsafe condition has been identified that is likely to exist or develop on other airplanes of the same type design registered in the United States, the proposed AD would require modification of the cabin and toilet fluorescent lighting systems. The actions would be required to be accomplished in accordance with the service bulletin described previously.

The FAA estimates that 10 airplanes of U.S. registry would be affected by this proposed AD, that it would take approximately 20 work hours per airplane to accomplish the proposed actions, and that the average labor rate is \$55 per work hour. Required parts would cost approximately \$3,600 per airplane. Based on these figures, the total cost impact of the proposed AD on U.S. operators is estimated to be \$47,000.

The regulations proposed herein would not have substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government. Therefore, in accordance with Executive Order 12612, it is determined that this proposal would not have sufficient federalism implications to warrant the preparation of a Federalism Assessment.

For the reasons discussed above, I certify that this proposed regulation (1) is not a "major rule" under Executive Order 12291; (2) is not a "significant rule" under the DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and (3) if promulgated, will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act. A copy of the draft regulatory evaluation prepared for this action is

contained in the Rules Docket. A copy of it may be obtained by contacting the Rules Docket at the location provided under the caption "ADDRESSES."

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Safety.

The Proposed Amendment

Accordingly, pursuant to the authority delegated to me by the Administrator, the Federal Aviation Administration proposes to amend 14 CFR part 39 of the Federal Aviation Regulations as follows:

PART 39—AIRWORTHINESS DIRECTIVES

1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 1354(a), 1421 and 1423; 49 U.S.C. 106(g); and 14 CFR 11.89.

§ 39.13 [Amended]

2. Section 39.13 is amended by adding the following new airworthiness directive:

British Aerospace: Docket 92-NM-64-AD.

Applicability: Model 125-600A, -700A, and -800A series airplanes; as listed in British Aerospace Service Bulletin 33-45-25A027A&B, dated December 23, 1991; certificated in any category.

Compliance: Required as indicated, unless accomplished previously.

To prevent electrical arcing and a resultant fire, accomplish the following:

(a) Within 180 days after the effective date of this AD, modify the cabin and toilet fluorescent lighting systems, in accordance with British Aerospace Service Bulletin 33-45-25A027A&B, dated December 23, 1991.

(b) An alternative method of compliance or adjustment of the compliance time, which provides an acceptable level of safety, may be used when approved by the Manager, Standardization Branch, ANM-113, FAA, Transport Airplane Directorate. The request shall be forwarded through an FAA Principal Maintenance Inspector, who may concur or comment and then send it to the Manager, Standardization Branch, ANM-113.

(c) Special flight permits may be issued in accordance with FAR 21.197 and 21.199 to operate the airplane to a location where the requirements of this AD can be accomplished.

Issued in Renton, Washington, on April 28, 1992.

N.B. Martenson,

Acting Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. 92-13048 Filed 6-3-92; 8:45 am]

BILLING CODE 4910-13-M

14 CFR Part 39

[Docket No. 92-NM-71-AD]

Airworthiness Directives; Fokker Model F-28 Mark 0100 Series Airplanes**AGENCY:** Federal Aviation Administration, DOT.**ACTION:** Notice of proposed rulemaking (NPRM).

SUMMARY: This notice proposes the adoption of a new airworthiness directive (AD) that is applicable to certain Fokker Model F-28 Mark 0100 series airplanes. This proposal would require reinforcing the lower right-hand wing skin at the fueling adapter. This proposal is prompted by results of recent tests, which revealed that fatigue cracks can develop in the lower right-hand wing skin at the attachment bolt holes of the fueling adapter. The actions specified by the proposed AD are intended to prevent reduced structural capability of the wing and fuel leakage.

DATES: Comments must be received by July 7, 1992.

ADDRESSES: Submit comments in triplicate to the Federal Aviation Administration (FAA), Transport Airplane Directorate, ANM-103, Attention: Rules Docket No. 92-NM-11-AD, 1601 Lind Avenue SW., Renton, Washington 98055-4056. Comments may be inspected at this location between 9 a.m. and 3 p.m., Monday through Friday, except Federal holidays.

The service information referenced in the proposed rule may be obtained from Fokker Aircraft USA, Inc., 1199 North Fairfax Street, Alexandria, Virginia 22314. This information may be examined at the FAA, Transport Airplane Directorate, 1601 Lind Avenue SW., Renton, Washington.

FOR FURTHER INFORMATION CONTACT: Mr. Mark Quam, Aerospace Engineer, Standardization Branch, ANM-113, FAA, Transport Airplane Directorate, 1601 Lind Avenue SW., Renton, Washington 98055-4056; telephone (206) 227-2145; fax (206) 227-1320.

SUPPLEMENTARY INFORMATION:**Comments Invited**

Interested persons are invited to participate in the making of the proposed rule by submitting such written data, views, or arguments as they may desire. Communications shall identify the Rules Docket number and be submitted in triplicate to the address specified above. All communications received on or before the closing date for comments, specified above, will be considered before taking action on the proposed rule. The proposals contained

in this notice may be changed in light of the comments received.

Comments are specifically invited on the overall regulatory, economic, environmental, and energy aspects of the proposed rule. All comments submitted will be available, both before and after the closing date for comments, in the Rules Docket for examination by interested persons. A report summarizing each FAA-public contact concerned with the substance of this proposal will be filed in the Rules Docket.

Commenters wishing the FAA to acknowledge receipt of their comments submitted in response to this notice must submit a self-addressed, stamped postcard on which the following statement is made: "Comments to Docket Number 92-NM-71-AD." The postcard will be date stamped and returned to the commenter.

Availability of NPRMs

Any person may obtain a copy of this NPRM by submitting a request to the FAA, Transport Airplane Directorate, ANM-103, Attention: Rules Docket No. 92-NM-71-AD, 1601 Lind Avenue SW., Renton, Washington 98055-4056.

Discussion

The Rijksluchtvaartdienst (RLD), which is the airworthiness authority for the Netherlands, recently notified the FAA that an unsafe condition may exist on certain Fokker Model F-28 Mark 0100 series airplanes. The RLD advises that results of recent tests conducted by the airplane manufacturer have revealed that fatigue cracks can develop in the lower right-hand wing skin at the attachment bolt holes of the fueling adapter. Fatigue cracks in this area, if not detected and corrected, could lead to reduced structural capability of the wing and fuel leakage.

Fokker has issued Service Bulletin SBF100-57-008, dated November 1, 1991, which describes procedures for reinforcing the lower right-hand wing skin at the fueling adapter by installing a new stringer and new internal and external doubler plates. The RLD classified this service bulletin as mandatory and issued Netherlands Airworthiness Directive BLA No. 91-131 in order to assure the continued airworthiness of these airplanes in the Netherlands.

This airplane model is manufactured in the Netherlands and is type certificated for operation in the United States under the provisions of § 21.29 of the Federal Aviation Regulations and the applicable bilateral airworthiness agreement. Pursuant to this bilateral airworthiness agreement, the RLD has

kept the FAA informed of the situation described above. The FAA has examined the findings of the RLD, reviewed all available information, and determined that AD action is necessary for products of this type design that are certificated for operation in the United States.

Since an unsafe condition has been identified that is likely to exist or develop on other airplanes of the same type design registered in the United States, the proposed AD would require reinforcing the lower right-hand wing skin at the fueling adapter. The actions would be required to be accomplished in accordance with the service bulletin described previously.

The FAA estimates that 20 airplanes of U.S. registry would be affected by this proposed AD, that it would take approximately 20 work hours per airplane to accomplish the proposed actions, and that the average labor rate is \$55 per work hour. Required parts would cost approximately \$880 per airplane. Based on these figures, the total cost impact of the proposed AD on U.S. operators is estimated to be \$39,600.

The regulations proposed herein would not have substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government. Therefore, in accordance with Executive Order 12612, it is determined that this proposal would not have sufficient federalism implications to warrant the preparation of a Federalism Assessment.

For the reasons discussed above, I certify that this proposed regulation (1) is not a "major rule" under Executive Order 12291; (2) is not a "significant rule" under the DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and (3) if promulgated, will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act. A copy of the draft regulatory evaluation prepared for this action is contained in the Rules Docket. A copy of it may be obtained by contacting the Rules Docket at the location provided under the caption "ADDRESSES."

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Safety.

The Proposed Amendment

Accordingly, pursuant to the authority delegated to me by the Administrator, the Federal Aviation Administration

proposes to amend 14 CFR part 39 of the Federal Aviation Regulations as follows:

PART 39—AIRWORTHINESS DIRECTIVES

1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 1354(a), 1421 and 1423; 49 U.S.C. 106(g); and 14 CFR 11.89.

§ 39.13 [Amended]

2. Section 39.13 is amended by adding the following new airworthiness directive:

Fokker: Docket 92-NM-71-AD.

Applicability: Model F-28 Mark 0100 series airplanes; serial numbers 11244 through 11287 inclusive, 11289, 11291, 11292, 11293, 11295, 11299, 11300, 11303, 11306, 11308, and 11310; certificated in any category.

Compliance: Required as indicated, unless accomplished previously.

To prevent reduced structural capability of the wing and fuel leakage, accomplish the following:

(a) Prior to the accumulation of 12,000 landings, or within 60 days after the effective date of this AD, whichever occurs later, reinforce the lower right-hand wing skin at the fueling adapter by installing a new stringer and new internal and external doubler plates, in accordance with Fokker Service Bulletin SBF100-57-008, dated November 1, 1991.

(b) An alternative method of compliance or adjustment of the compliance time, which provides an acceptable level of safety, may be used when approved by the Manager, Standardization Branch, ANM-113, FAA, Transport Airplane Directorate. The request shall be forwarded through an FAA Principal Maintenance Inspector, who may concur or comment and then send it to the Manager, Standardization Branch, ANM-113.

Note: Information concerning the existence of approved alternative methods of compliance with this airworthiness directive, if any, may be obtained from the Standardization Branch, ANM-113.

(c) Special flight permits may be issued in accordance with FAR 21.197 and 21.199 to operate the airplane to a location where the requirements of this AD can be accomplished.

Issued in Renton, Washington, on May 7, 1992.

Darrell M. Pederson,

Acting Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. 92-13047 Filed 6-3-92; 8:45 am]

BILLING CODE 4910-13-M

ACTION: Supplemental notice of proposed rulemaking; reopening of comment period.

SUMMARY: This notice revises an earlier proposed airworthiness directive (AD), applicable to McDonnell Douglas Model DC-10 and KC-10A (military) series airplanes, that would have reduced the repetitive inspection intervals for repaired spar caps and upper rear skin panels, and would have expanded the inspection area. That proposal was prompted by service experience and additional data presented by the manufacturer that indicated that such actions are necessary to ensure the continued airworthiness of these airplanes. This action revises the proposed rule by reducing the compliance time for the initial inspection of the expanded area, and by providing an alternative method of inspection. The actions specified by this proposed AD are intended to prevent loss of the fail-safe capability of the horizontal stabilizer.

DATES: Comments must be received by July 6, 1992.

ADDRESSES: Submit comments in triplicate to the Federal Aviation Administration (FAA), Transport Airplane Directorate, ANM-103, Attention: Rules Docket No. 91-NM-222-AD, 1601 Lind Avenue SW., Renton, Washington 98055-4056. Comments may be inspected at this location between 9 a.m. and 3 p.m., Monday through Friday, except Federal holidays.

The service information referenced in the proposed rule may be obtained from McDonnell Douglas Corporation, P.O. Box 1771, Long Beach, California 90846-0001, Attention: Business Unit Manager, Technical Publications—Technical Administrative Support, C1-L5B. This information may be examined at the FAA, Transport Airplane Directorate, 1601 Lind Avenue SW., Renton, Washington.

FOR FURTHER INFORMATION CONTACT: Ms. Maureen Moreland, Aerospace Engineer, Los Angeles Aircraft Certification Office, ANM-121L, FAA, Transport Airplane Directorate, 3229 East Spring Street, Long Beach, California 90806-2425; telephone (310) 988-5238; fax (310) 988-5210.

SUPPLEMENTARY INFORMATION:

Comments Invited

Interested persons are invited to participate in the making of the proposed rule by submitting such written data, views, or arguments as they may desire. Communications shall identify the Rules Docket number and be submitted in triplicate to the address

specified above. All communications received on or before the closing date for comments, specified above, will be considered before taking action on the proposed rule. The proposals contained in this notice may be changed in light of the comments received.

Comments are specifically invited on the overall regulatory, economic, environmental, and energy aspects of the proposed rule. All comments submitted will be available, both before and after the closing date for comments, in the Rules Docket for examination by interested persons. A report summarizing each FAA-public contact concerned with the substance of this proposal will be filed in the Rules Docket.

Commenters wishing the FAA to acknowledge receipt of their comments submitted in response to this notice must submit a self-addressed, stamped postcard on which the following statement is made: "Comments to Docket Number 91-NM-222-AD." The postcard will be date stamped and returned to the commenter.

Availability of NPRMs

Any person may obtain a copy of this NPRM by submitting a request to the FAA, Transport Airplane Directorate, ANM-103, Attention: Rules Docket No. 91-NM-222-AD, 1601 Lind Avenue SW., Renton, Washington 98055-4056.

Discussion

A proposal to amend part 39 of the Federal Aviation Regulations to add an airworthiness directive (AD), applicable to McDonnell Douglas Model DC-10 and KC-10A (Military) series airplanes, was published as a notice of proposed rulemaking (NPRM) in the Federal Register on January 8, 1992 (57 FR 656). That NPRM would have superseded AD 87-06-53 R2, Amendment 39-6149 (54 FR 8527, March 1, 1989), to reduce the repetitive inspection interval for cracked spar caps from 2,000 landings to 500 landings, and would have required an 80-flight hour inspection interval for stop-drilled cracks in the skin panels. That NPRM was prompted by reports indicating that fatigue cracks that were previously blended out in the barrel nut holes of the spar cap have cracked beyond the established limits. The cracking occurred prior to the 2,000-landing inspection interval required by the existing AD. The manufacturer has furnished data to substantiate that the stop-drilling of cracks that are within specified limits on the skin panels is an acceptable procedure for addressing this cracking problem, provided that the area

14 CFR Part 39

[Docket No. 91-NM-222-AD]

Airworthiness Directives; McDonnell Douglas Model DC-10 and KC-10A (Military) Series Airplanes

AGENCY: Federal Aviation Administration, DOT.

is repetitively inspected at reduced inspection intervals.

The proposed rule also would have required an initial inspection of the inboard-most end of the horizontal stabilizer rear upper spar cap vertical tang, in accordance with the "bolt hole" method, stress coining of the vertical tang attachment holes, and repetitive inspections of the vertical tang in accordance with the "surface probe" method at intervals not to exceed 3,500 landings. That action was prompted by reports of four instances of fatigue cracking found in the inboard-most end of the horizontal stabilizer rear spar upper cap vertical tang. Such cracking, if not corrected, could result in the loss of the fail-safe capability of the horizontal stabilizer.

Since the issuance of that NPRM, the FAA has determined (based on comments received from operators and additional technical discussions with the manufacturer) that the option to use the "surface probe" method for the initial eddy current inspection of the vertical tang, as an alternative to the "bolt hole" inspection method, provides an acceptable level of safety. Conducting the eddy current inspection of the vertical tang using the "bolt hole" inspection method takes significantly more work hours than the "surface probe" inspection method. This is due to the complexity of gaining access to the interior of the horizontal stabilizer that is required in order to conduct the inspection using the "bolt hole" inspection method. Both the "surface probe" and the "bolt hole" inspection methods are described in McDonnell Douglas Service Bulletin A55-18, Revision 4, dated September 10, 1991. The proposal has been revised to provide an option to use the "surface probe" inspection method for the initial inspection of the vertical tang.

The FAA has also determined that in order to ensure the structural integrity of the horizontal stabilizer rear upper spar cap, the initial eddy current inspection of the vertical tang must be expedited. A 90-day compliance time for the initial eddy current inspection has been established and paragraph (e) of the proposal has been changed accordingly. This proposed compliance time was established in order to determine the status of the vertical tang on all affected airplanes within the same set time frame. Since the option to use the "surface probe" method for the initial inspection has been added, the 90-day compliance time should provide enough time for operators to schedule the required inspections and modifications,

while providing an acceptable level of safety.

Since these changes expand the scope of the originally proposed rule, the FAA has determined that it is necessary to reopen the comment period to provide additional opportunity for public comment.

There are approximately 423 Model DC-10 series airplanes of the affected design in the worldwide fleet. The FAA estimates that 153 airplanes of U.S. registry would be affected by this proposed AD, that it would take approximately 25 work hours per airplane to accomplish the proposed actions, and that the average labor rate is \$55 per work hour. Based on these figures, the total cost impact of the proposed AD on U.S. operators is estimated to be \$210,375 or \$1,375 per airplane.

The regulations proposed herein would not have substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government. Therefore, in accordance with Executive Order 12612, it is determined that this proposal would not have sufficient federalism implications to warrant the preparation of a Federalism Assessment.

For the reasons discussed above, I certify that this proposed regulation (1) is not a "major rule" under Executive Order 12291; (2) is not a "significant rule" under the DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and (3) if promulgated, will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act. A copy of the draft regulatory evaluation prepared for this action is contained in the Rules Docket. A copy of it may be obtained by contacting the Rules Docket at the location provided under the caption "ADDRESSES."

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Safety.

The Proposed Amendment

Accordingly, pursuant to the authority delegated to me by the Administrator, the Federal Aviation Administration proposes to amend 14 CFR part 39 of the Federal Aviation Regulations as follows:

PART 39—AIRWORTHINESS DIRECTIVES

1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 1354(a), 1421 and 1423; 49 U.S.C. 106(g); and 14 CFR 11.89.

§ 39.13 [Amended]

2. Section 39.13 is amended by adding the following new airworthiness directive:

McDonnell Douglas: Docket 91-NM-222-AD.

Applicability: Model DC-10 and KC-10A (military) series airplanes, certificated in any category.

Compliance: Required as indicated, unless accomplished previously.

To prevent failure of the horizontal stabilizer rear upper spar cap and/or upper rear skin panel due to fatigue cracking, accomplish the following:

(a) Prior to the accumulation of 30,000 flight hours or 7,500 landings, whichever occurs earlier, or within 15 days after August 14, 1987 (the effective date of AD 87-06-53 R1, Amendment 39-5694), whichever occurs later, unless already accomplished within the last 120 days since August 14, 1987, conduct a dye penetrant or eddy current inspection of the horizontal stabilizer upper outer section rear spar cap and a visual inspection of the horizontal stabilizer upper outer rear skin panel, in accordance with the "Accomplishment Instructions" of McDonnell Douglas Alert Service Bulletin A55-18, dated March 23, 1987; or Revision 1, dated May 21, 1987; or Revision 2, dated February 8, 1988; or Revision 3, dated August 17, 1990; or Revision 4, dated September 10, 1991.

(b) Prior to the accumulation of 2,000 landings after accomplishing the inspections required by paragraph (a) of this AD, or within 100 landings after March 27, 1989 (the effective date of AD 87-06-53 R2, Amendment 39-6149), whichever occurs later, and thereafter at intervals not to exceed 2,000 landings, except as provided below, repeat the dye penetrant or eddy current inspection required by paragraph (a) of this AD.

(c) If the spar cap has been repaired by removing/blending out a crack in accordance with the method described in McDonnell Douglas Service Bulletin A55-18, Revision 4, dated September 10, 1991 (hereafter, referred to as the "Service Bulletin"), repeat the dye penetrant or eddy current inspection of the spar required by paragraph (a) of this AD prior to the accumulation of 500 landings after the effective date of this amendment, or within 2,000 landings after the last inspection, whichever occurs first. Thereafter, repeat the dye penetrant or eddy current inspection at intervals not to exceed 500 landings.

(d) If the skin panel has been repaired by stop drilling a crack in accordance with the method described in the Service Bulletin, repeat the visual inspection of the skin panel required by paragraph (a) of this AD prior to the accumulation of 80 flight hours after the effective date of this AD, and thereafter at intervals not to exceed 80 flight hours.

(e) Within 90 days after the effective date of this AD, conduct an eddy current inspection of the inboard-most end of the horizontal stabilizer rear spar cap upper vertical tang at station XRS-63.810, in accordance with either the "bolt hole" or

"surface probe" method as described in the Service Bulletin.

(1) If the "surface probe" method is used, and no cracks are found, prior to the accumulation of 2,000 landings after the inspection, inspect the vertical tang in accordance with the "bolt hole" method described in the Service Bulletin. If no cracks are found as a result of the "bolt hole" method, prior to further flight, stress coin the attachment holes and install oversize attachments. Thereafter, at intervals not to exceed 3,500 landings, conduct an eddy current inspection utilizing the "surface probe" method, in accordance with the Service Bulletin.

(2) If the "bolt hole" method is used, and no cracks are found, prior to further flight, stress coin the attachment holes and install oversize attachments. Thereafter, at intervals not to exceed 3,500 landings, conduct an eddy current inspection utilizing the "surface probe" method, in accordance with the Service Bulletin.

(f) If any crack is found as a result of the inspections required by this AD, that is within the limits specified in the Service Bulletin, accomplish the procedures specified in paragraph (f)(1), (f)(2), or (f)(3) of this AD, as applicable:

(1) For cracks in the spar cap that are within the limits specified in Table I of the Service Bulletin: Repair prior to further flight, in accordance with paragraph 4.(b) of the Service Bulletin.

(2) For cracks in the skin panel that are within the limits specified in Table II of the Service Bulletin: Repair prior to further flight, in accordance with paragraph 4.(c) of the Service Bulletin.

(3) For cracks in the vertical tang that are within the limits specified in paragraphs 4.3(a)(1), 4.3(a)(2) and 4.3(b) of the Service Bulletin: Repair prior to further flight, in accordance with 4.3(b) of the Service Bulletin.

(g) If any crack is found as a result of the inspections required by this AD that exceed the limits specified in the Service Bulletin, prior to further flight, repair in a manner approved by the Manager, Los Angeles Aircraft Certification Office, FAA, Transport Airplane Directorate.

(h) An alternative method of compliance or adjustment of the compliance time, which provides an acceptable level of safety, may be used when approved by the Manager, Los Angeles Aircraft Certification Office (ACO), FAA, Transport Airplane Directorate. The request shall be forwarded through an FAA Principal Maintenance Inspector, who may concur or comment and then send it to the Manager, Los Angeles ACO.

(i) Special flight permits may be issued in accordance with FAR 21.197 and 21.199 to operate the airplane to a location where the requirements of this AD can be accomplished.

Issued in Renton, Washington, on May 4, 1992.

Darrell M. Pederson,

Acting Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. 92-13051 Filed 6-3-92; 8:45 am]

BILLING CODE 4910-13-M

Office of the Secretary

14 CFR Part 382

Workshop on Lift Boarding Devices for Small Aircraft

AGENCY: Department of Transportation (DOT), Office of the Secretary.

ACTION: Schedule of workshop meeting.

SUMMARY: The Department of Transportation gives notice, as required by the Federal Advisory Committee Act (Pub. L. 92-463), of the time and location of meeting of a workshop on Lift Boarding Devices for Small (Commuter) Aircraft.

DATES: Meeting of the workshop is scheduled for Wednesday, June 24, and Thursday, June 25, 1992.

ADDRESSES: The workshop meeting will be held in Conference Rooms 8334 and 6244, respectively, of the Department of Transportation (Nassif Building) 400 7th Street, SW., Washington, DC.

FOR FURTHER INFORMATION CONTACT:

Donald R. Trilling, Director, Office of Transportation Regulatory Affairs, Department of Transportation, 400 7th Street, SW., Washington, DC 20590, telephone (202) 366-4220.

Ira Laster Jr., Senior Program Coordinator, Department of Transportation, Office of Transportation Regulatory Affairs, 400 7th Street, SW., Washington, DC 20590, Telephone (202) 366-4859.

SUPPLEMENTARY INFORMATION: The purpose of the workshop is to provide information to the Department on the present status of the technology, safety, costs, and availability of lifts for small aircraft. Such lifts would facilitate the boarding of disabled passengers. We also will explore a number of issues concerning the need for standards, who should pay for lifts and alternative funding sources. With the information received, we hope to determine whether and when to mandate lift use through amendment of DOT's Air Carrier Access Act (ACAA) rule.

Background

Concurrent with the March 1990 publication of DOT's ACAA rule, the Department issued an Advanced Notice of Proposed Rulemaking seeking information on whether a suitable lift passenger boarding device exists to serve relevant small (less than 30 seats) aircraft in a safe, efficient manner at reasonable costs. We received some comments, but not enough definitive data on the workability, safety, costs and availability of lifts to undertake a formal rulemaking.

In the ensuing two years, DOT headquarters and Federal Aviation Administration (FAA) staff have participated with staff of the Paralyzed Veterans of America, Regional Airline Association (RAA), individual airlines and lift manufacturers in discussions and demonstrations to become acquainted with various types of lifts and their suitability for use on different models of small aircraft. At the same time, a number of small carriers and lift manufacturers have been engaged in ongoing testing of lift prototypes at various airports.

To date, however, it appears only a few investigating carriers or airports find the lifts capable of meeting all their requirements, with respect to flexibility, maintainability, and accommodation of the tight physical requirements of small aircraft. We understand, however, that all parties have been working together to resolve many of these problems and that at least one carrier, American Eagle, has been especially active in this regard.

The Department is conducting this workshop to exchange information on these issues, to put all parties on common ground as to today's state of the art in lift development, and to provide a factual basis for follow-on rulemaking to the Air Carrier Access Act rules.

Persons who might wish to participate should be aware that the conference facilities are small and have limited seating capacity.

Jeffrey N. Shane,

Assistant Secretary for Policy and International Affairs.

[FR Doc. 92-13006 Filed 6-3-92; 8:45 am]

BILLING CODE 4910-62-M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

21 CFR Part 146

[Docket No. 91P-0195]

Orange Juice Products; Proposed Amendment of the Standards of Identity

AGENCY: Food and Drug Administration, HHS.

ACTION: Proposed rule.

SUMMARY: The Food and Drug Administration (FDA) is proposing to amend the standards of identity for orange juice products in 21 CFR Part 146 to allow the inclusion of juice from the hybrid species 1/2 *Citrus sinensis* (C. sinensis) × 3/8 *Citrus reticulata* (C.

reticulata) $\times$ 1/8 (*Citrus paradisi* (*C. paradisi*) (commonly referred to by the varietal name of "Ambersweet") into all orange juice products in the same manner as is juice from oranges of the species *C. sinensis*. The proposal is based on a joint petition by industry and State government agencies. This action will permit greater flexibility in the manufacturing of orange juice products and will promote honesty and fair dealing in the interest of consumers.

DATES: Written comments by August 3, 1992. The agency proposes that any final rule that may be issued based upon this proposal shall become effective 60 days after date of publication of the final rule in the Federal Register.

ADDRESSES: Written comments to the Dockets Management Branch (HFA-305), Food and Drug Administration, rm. 1-23, 12420 Parklawn Dr., Rockville, MD 20857.

FOR FURTHER INFORMATION CONTACT: James F. Lin, Center for Food Safety and Applied Nutrition (HFF-414), Food and Drug Administration, 200 C Street, SW., Washington, DC 20204, 202-485-0122.

SUPPLEMENTARY INFORMATION: The Florida Department of Citrus, Florida Department of Agriculture and Consumer Services, Florida Citrus Mutual, Florida Citrus Processors Association, Florida Citrus Packers, Indian River Citrus League, Gulf Citrus Growers Association, Inc., Citrus Grower Associates, Inc., National Juice Products Association, and Florida Farm Bureau have filed jointly a food standards petition dated May 13, 1991. The petitioners requested that FDA amend the U.S. standards of identity for orange juice (21 CFR 146.135), pasteurized orange juice (21 CFR 146.140), canned orange juice (21 CFR 146.141), frozen concentrated orange juice (21 CFR 146.146), and orange juice for manufacturing (21 CFR 146.151), to allow the inclusion of juice from the Ambersweet orange hybrid into all orange juice products in the same manner as is juice from oranges of the species *C. sinensis*. The standards of identity for frozen orange juice (21 CFR 146.137), orange juice from concentrate (21 CFR 146.145), reduced acid frozen concentrated orange juice (21 CFR 146.148), canned concentrated orange juice (21 CFR 146.150), orange juice with preservative (21 CFR 146.152), concentrated orange juice for manufacturing (21 CFR 146.153), and concentrated orange juice with preservative (21 CFR 146.154) cross-reference 21 CFR 146.135, 146.146, and 146.151. To the extent that these standards are modified by amendments to the standards that they cross-

reference, the petitioners requested that these standards also be modified.

I. Statement of Grounds

The "Ambersweet" orange is an early maturing, cold-resistant hybrid developed and recently released by the United States Department of Agriculture (USDA). Ambersweet fruits are 7.62 to 10.16 centimeters (3 to 4 inches) in diameter, round in shape, and occasionally have a small navel. They resemble navel oranges more than other orange varieties. This particular hybrid is composed of 1/2 *C. sinensis* $\times$ 3/8 *C. reticulata* $\times$ 1/8 *C. paradisi*. It is widely regarded as the most outstanding variety of orange to result from a 25-year USDA breeding program aimed at developing cold-resistant trees with deeper colored fruit and juice with consistent high-quality taste (ref. 1).

The petitioners contended that authorization for the use of Ambersweet orange juice products would have the advantage of providing consumers with high quality, good tasting orange juice at a lower price. The petitioners asserted that inclusion of this early maturing domestic orange in orange juice products in the same manner as oranges of the species *C. sinensis* (the only species permitted by the U.S. standard of identity for orange juice (§ 146.135) and the primary species authorized for all other standardized orange juice products) would: (1) Lower the cost of blending orange varieties by adding an early maturing domestic orange instead of continuing industry reliance on more expensive off-season imported oranges obtained from the species *C. sinensis*; (2) reduce grower vulnerability to damaging freezes; (3) reduce interseason storage requirements, and (4) make it commercially feasible to propagate the Ambersweet variety in the U.S. The petitioners stated that these cost-saving measures would provide economic benefits for both citrus producers and processors, as well as for consumers of processed citrus products.

II. The Proposal

The U.S. standard of identity for orange juice (21 CFR 146.135) defines orange juice as "the unfermented juice obtained from mature oranges of the species *C. sinensis*." The addition of juice of other species of oranges and their hybrids is not permitted, nor is such addition permitted by the U.S. standard of identity for frozen orange juice (§ 146.137), which cross-references § 146.135.

The juice of two other species of oranges are permitted, with certain specified limitations, for other orange juice products for which FDA has

established standards of identity. Up to 10 percent of the juice from mature oranges of the species *C. reticulata* and their hybrids may be added to pasteurized orange juice (§ 146.140), canned orange juice (§ 146.141), orange juice for manufacturing (§ 146.151), and, by cross-reference, orange juice with preservative (§ 146.152).

Up to 10 percent of the juice from oranges of the species *C. reticulata* and their hybrids and up to 5 percent of the juice from oranges of the species *Citrus aurantium* may be added to frozen concentrated orange juice (§ 146.146) and, by cross-reference, orange juice from concentrate (§ 146.145), reduced acid frozen concentrated orange juice (§ 146.148), canned concentrated orange juice (§ 146.150), concentrated orange juice for manufacturing (§ 146.153), and concentrated orange juice with preservative (§ 146.154).

The petitioners have requested that FDA amend all of the orange juice standards of identity in 21 CFR part 146 to allow for the inclusion of juice from the species 1/2 *C. sinensis* $\times$ 3/8 *C. reticulata* $\times$ 1/8 *C. paradisi* (commonly referred to by the varietal name "Ambersweet") in all orange juice products in the same manner as juice from oranges of the species *C. sinensis*. Specifically, the petitioners have requested that FDA amend the standard of identity for orange juice (§ 146.135) by adding the phrase "and of the hybrid species described as 1/2 *C. sinensis* $\times$ 3/8 *C. reticulata* $\times$ 1/8 *C. paradisi*" to the end of the first sentence of paragraph (a) (§ 146.135(a)).

To make this proposed amendment applicable to pasteurized orange juice (§ 146.140), canned orange juice (§ 146.141), and orange juice for manufacturing (§ 146.151), the petitioners requested that the standards of identity for these products be amended by adding the phrase "(except that this limitation shall not apply to the hybrid species described in § 146.135)" to the end of the first sentence of paragraph (a) in §§ 146.140 and 146.141 (§§ 146.140(a) and 146.141(a)) and to the end of the second sentence of paragraph (a) in § 146.151 (§ 146.151(a)). The petitioners also requested that FDA amend the standard of identity for frozen concentrated orange juice (§ 146.146) by inserting the phrase "(except for the hybrid species described in § 146.135)" in the second sentence of paragraph (a) as follows: "However, in the concentrated blend the volume of juice from *C. reticulata* (except for the hybrid species described in § 146.135) shall not * * * (§ 146.146(a))."

The petitioners noted that the U.S. standards of identity for frozen orange juice (§ 146.137), orange juice from concentrate (§ 146.145), reduced acid frozen concentrated orange juice (§ 146.148), canned concentrated orange juice (§ 146.150), orange juice with preservative (§ 146.152), concentrated orange juice for manufacturing (§ 146.153), and concentrated orange juice with preservative (§ 146.154) cross-reference §§ 146.135, 146.146, and 146.151 and would be amended by the changes to those sections. FDA concurs that the standards would be amended similarly by the cross-reference.

In support of their petition, the petitioners submitted several references, including information on a number of taste-test studies. One such study was a double blind, side-by-side USDA comparison study in which juice samples containing no Ambersweet juice, 50 percent Ambersweet juice, and 100 percent Ambersweet juice were graded by experienced USDA inspectors. All samples were scored as having "very good" flavor, surpassing the minimum USDA Grade A flavor requirements for orange juice (ref. 2).

The flavor chemistry profiles of juice products obtained from Ambersweet were analyzed and compared to the profiles of similar juice products from tangerine (*C. reticulata*), grapefruit (*C. paradisi*), and other orange (*C. sinensis*) varieties. The results showed that the flavor composition and profiles of juice from Ambersweet oranges are very similar to those of orange juice from *C. sinensis* but are different from those of juice from *C. reticulata*, other *C. reticulata* hybrids, and *C. paradisi* (ref. 3).

The petitioners also noted that additional studies on yield, Brix-acid ratio, color, flavor, and concentration characteristics of Ambersweet juice demonstrated that Ambersweet oranges produce good tasting orange juice with good color early in the season (ref. 4). Based on several years of studies on the characteristics of Ambersweet fruit and its processed juice, the Florida Department of Citrus adopted a regulation, effective August 1990, naming the Ambersweet orange and classifying Ambersweet as an orange for purposes of determining maturity under state maturity laws (Florida Administration Code (1990) § 20-13.011).

FDA believes that the petitioners have provided sufficient grounds to warrant issuance of a proposal to amend the orange juice product standards in 21 CFR part 146 to provide for an additional orange hybrid, "Ambersweet," that is to be used in unlimited amounts in these juice

products. The agency requests comments from processors and consumers who have had experience with this new hybrid. In particular, the agency requests comments from the public on its acceptance as an orange juice beverage product.

In the interest of increased flexibility in the orange juice standards, FDA requests comments on these amendments as well as on other changes that would provide processors with lower cost alternatives but that would be in the interest of consumers. FDA questions whether at this time there are other orange hybrids that would be suitable for use without limitations in orange juice products as the petitioners claim for the Ambersweet hybrid. FDA points out that any suggested modifications for increased flexibility in the standards should not result in products that could be misleading, deceptive, or not otherwise in the interest of consumers. FDA believes that consumers purchasing orange juice labeled in accordance with the orange juice standards of identity expect, and should receive, certain typical organoleptic characteristics in these foods. Thus, careful consideration should be given to the use of new ingredients or juice from sources that could change the properties of the food. Suggestions for increased flexibility in the standards should be supported, where possible, with data on the need for the changes and on the anticipated effects on the food and on consumer acceptance of the products so modified.

Based on the information presented by the petitioners, FDA tentatively concludes that amending the standards of identity for orange juice products as set forth below to provide for the use of juice from the hybrid species $\frac{1}{2}$ *C. sinensis* X $\frac{1}{2}$ *C. reticulata* X $\frac{1}{2}$ *C. paradisi* on the same basis as that of oranges of the species *C. sinensis* will provide consumers with orange juice products at lower cost, with no denigration of orange juice flavor, and that these amendments will promote honesty and fair dealing in the interest of consumers.

Therefore, the agency is proposing to amend the U.S. standards of identity for orange juice (21 CFR 146.135), pasteurized orange juice (21 CFR 146.140), canned orange juice (21 CFR 146.141), frozen concentrated orange juice (21 CFR 146.146), and orange juice for manufacturing (21 CFR 146.151) and, by cross reference, the standards of identity for frozen orange juice (21 CFR 146.137), orange juice from concentrate (21 CFR 146.145), reduced acid frozen concentrated orange juice (21 CFR

146.148), canned concentrated orange juice (21 CFR 146.150), orange juice with preservative (21 CFR 146.152), concentrated orange juice for manufacturing (21 CFR 146.153), and concentrated orange juice with preservative (21 CFR 146.154), to include juice from the hybrid species described as $\frac{1}{2}$ *C. sinensis* X $\frac{1}{2}$ *C. reticulata* X $\frac{1}{2}$ *C. paradisi* in the same manner as the juice from oranges of the species *C. sinensis*, i.e., without limits on the amount of juice from the hybrid which may be used in the final product.

Minor editorial changes in reference to *C. reticulata* hybrids have been made for clarity in the revised standards set out below.

III. Economic Impact

FDA has examined the economic implications of the proposed rule to amend certain standards of identity for orange juice products in 21 CFR part 146 as required by Executive Orders 12291 and 12612, and by the Regulatory Flexibility Act (Pub. L. 96-354). Executive Order 12291 compels Federal agencies to use cost-benefit analysis as a component of decisionmaking, and Executive Order 12612 requires that Federal agencies ensure that Federal solutions, rather than State or local solutions, are necessary. The Regulatory Flexibility Act requires regulatory relief for small businesses where feasible. The agency finds that this proposed rule is not a major rule as defined by Executive Order 12291. In accordance with the Regulatory Flexibility Act, FDA has also determined that this proposed rule will not have a significant adverse impact on a substantial number of small businesses. Finally, because this regulation applies to food for interstate trade, and individual state regulations could hinder interstate trade, FDA finds that there is no substantial Federalism issue that would require an analysis under Executive Order 12612.

Options associated with the petition include: (1) Not amending the standards to provide for the Ambersweet hybrid, (2) amending the standards to include only the requested change, or (3) amending the standards to provide for any orange hybrid that falls within specified guidelines.

The cost of failing to amend these standards, option (1), is reduced variety in orange juice products that would be available to consumers.

The benefit of amending these standards, option (2), will be to allow for increased variety in orange juice products for consumers. The marginal costs of amending the standards for only the requested change is the opportunity

cost of not allowing them to be more flexible for future technological changes.

The benefits of option (3) would be to allow firms to market such products without amending the food standards through informal rulemaking. This could ultimately promote innovation in the quality of products and lower production costs. On the other hand, the agency is also concerned about increased transactions costs (costs of using the market) if products marketed under the term "orange juice" are made with other juices. To the extent hybrids and other juices become far removed from "traditional" orange juice, the term "orange juice" will convey less information as an aid to selection of a juice product.

Additionally, FDA believes that the term "orange juice" conveys an extremely homogeneous meaning to consumers as to the contents of these products. Finally, before taking any action like option (3), FDA would have to ensure that such action would promote honesty and fair dealing in the interests of consumers.

Although FDA would like to provide for future technological change in the manufacture of orange juice (without technical amendments to the standard), FDA is not aware of any new hybrids under development that could be used without limitations. Even if such developments were underway, FDA does not have sufficient information to provide boundaries for use of the term "orange juice" that would encompass all future technological development. Finally, it should be noted that manufacturers are currently able to sell any blend of citrus juice products, provided they are appropriately labeled. Thus, FDA has not chosen option (3), providing for any orange hybrid without limitations. However, FDA specifically requests comments on these options.

IV. Environmental Impact

The agency has determined under 21 CFR 25.24(b)(1) that this action is of a type that does not individually or cumulatively have a significant effect on the human environment. Therefore, neither an environmental assessment nor an environmental impact statement is required.

V. Request for Comments

Interested persons may, on or before August 3, 1992 submit to the Dockets Management Branch (address above) written comments regarding this proposal. Two copies of any comments are to be submitted, except that individuals may submit one copy. Comments are to be identified with the docket number found in brackets in the

heading of this document. Received comments may be seen in the Dockets Management Branch between 9 a.m. and 4 p.m., Monday through Friday.

VI. References

The following information has been placed on display in the Dockets Management Branch (address above) and may be seen by interested persons between 9 a.m. and 4 p.m. Monday through Friday.

1. Hearn, C.J., "Yield and Fruit Quality of Ambersweet Orange Hybrid on Different Rootstocks," proceedings of the Florida State Horticultural Society, 102:75-78, 1989.
2. Carter, R.D., "USDA Ambersweet Flavor Comparison Tests," unpublished report, Florida Department of Citrus, Lake Alfred, FL, 1991.
3. Moshonas, M.G., P.E. Shaw, and R.D. Carter, "The Ambersweet Orange Hybrid: Compositional Evidence for Variety Classification," Journal of Agricultural and Food Chemistry, 39:1416-1421, 1991.
4. Barros, S.M., R.D. Carter, and C.J. Hearn, "Ambersweet Orange—Processed Juice Quality Characteristics," proceedings of the Florida State Horticultural Society, 103:269-272, 1990.
5. Barrett, H.C. and A.M. Rhodes, "A Numerical Taxonomic Study of Affinity Relationships in Cultivated Citrus and Its Close Relatives," Systematic Botany, 1:105-136, 1976.
6. Telephone conversation between Kristen Chadwell, Department of Citrus, Florida and Richard A. Williams, Jr., Center for Food Safety and Applied Nutrition, FDA, February 13, 1992.

List of Subjects in 21 CFR Part 146

Food grades and standards, Fruit juices.

Therefore, under the Federal Food, Drug, and Cosmetic Act, and under the authority delegated to the Commissioner of Food and Drugs and redelegated to the Director, Center for Food Safety and Applied Nutrition, it is proposed that 21 CFR Part 146 be amended as follows:

PART 146—CANNED FRUIT JUICES

1. The authority citation for 21 CFR Part 146 continues to read as follows:

Authority: Secs. 201, 401, 403, 409, 701, 706 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321, 341, 343, 348, 371, 376).

2. Section 146.135 is amended by revising paragraph (a) to read as follows:

§ 146.135 Orange juice.

(a) Orange juice is the unfermented juice obtained from mature oranges of the species *Citrus sinensis* and of the hybrid species described as $\frac{1}{2}$ *Citrus sinensis* X $\frac{1}{2}$ *Citrus reticulata* X $\frac{1}{8}$ *Citrus paradisi*. Seeds (except embryonic seeds and small fragments of

seeds that cannot be separated by current good manufacturing practice) and excess pulp are removed. The juice may be chilled, but is not frozen.

3. Section 146.140 is amended by revising the first sentence in paragraph (a) to read as follows:

§ 146.140 Pasteurized orange juice.

(a) Pasteurized orange juice is the food prepared from unfermented juice obtained from mature oranges as specified in § 146.135, to which may be added not more than 10 percent by volume of the unfermented juice obtained from mature oranges of the species *Citrus reticulata* or *Citrus reticulata* hybrids (except that this limitation shall not apply to the hybrid species described in § 146.135). * * *

4. Section 146.141 is amended by revising the first sentence in paragraph (a) to read as follows:

§ 146.141 Canned orange juice.

(a) Canned orange juice is the food prepared from orange juice as specified in § 146.135 or frozen orange juice as specified in § 146.137, or a combination of both, to which may be added not more than 10 percent by volume of the unfermented juice obtained from mature oranges of the species *Citrus reticulata* or *Citrus reticulata* hybrids (except that this limitation shall not apply to the hybrid species described in § 146.135). * * *

5. Section 146.146 is amended by revising the first two sentences in paragraph (a) to read as follows:

§ 146.146 Frozen concentrated orange juice.

(a) Frozen concentrated orange juice is the food prepared by removing water from the juice of mature oranges as provided in § 146.135, to which may be added unfermented juice obtained from mature oranges of the species *Citrus reticulata*, other *Citrus reticulata* hybrids, or of *Citrus aurantium*, or both. However in the unconcentrated blend, the volume of juice from *Citrus reticulata* or *Citrus reticulata* hybrids shall not exceed 10 percent (except that this limitation shall not apply to the hybrid species described in § 146.135 and from *Citrus aurantium* shall not exceed 5 percent). * * *

6. Section 146.151 is amended by revising the second sentence in paragraph (a) to read as follows:

§ 146.151 Orange juice for manufacturing.

(a) * * * It is prepared from unfermented juice obtained from oranges as provided in § 146.135, except that the oranges may deviate from the standards for maturity in that they are below the minimum for Brix and Brix-acid ratio for such oranges, and to which juice may be added not more than 10 percent by volume of the unfermented juice obtained from oranges of the species *Citrus reticulata* or *Citrus reticulata* hybrids (except that this limitation shall not apply to the hybrid species described in § 146.135). * * *

Dated: May 1, 1992.

Douglas L. Archer,

Acting Director, Center for Food Safety and Applied Nutrition.

[FR Doc. 92-13033 Filed 6-3-92; 8:45 am]

BILLING CODE 4160-01-M

DEPARTMENT OF THE TREASURY**Bureau of Alcohol, Tobacco and Firearms****27 CFR Part 9**

[Notice No. 741]

RIN 1512-AA07

Spring Mountain Viticultural Area (91F-067P)

AGENCY: Bureau of Alcohol, Tobacco and Firearms (ATF), Treasury.

ACTION: Notice of proposed rulemaking.

SUMMARY: The Bureau of Alcohol, Tobacco and Firearms (ATF) is considering the establishment of a viticultural area located in Napa County, California, to be known as "Spring Mountain." This proposal is the result of a petition filed on behalf of Marston Vineyards and York Creek Vineyards.

ATF believes that the establishment of viticultural areas and the subsequent use of viticultural area names as appellations of origin in wine labeling and advertising allows wineries to designate the specific areas where the grapes used to make the wine were grown and enables consumers to better identify the wines they purchase.

DATES: Written comments must be received by August 3, 1992.

ADDRESSES: Send written comments to: Chief, Wine and Beer Branch, Bureau of Alcohol, Tobacco and Firearms, P.O. Box 50221, Washington, DC 20091-0221, Attn: Notice No. 741.

FOR FURTHER INFORMATION CONTACT: Marjorie D. Ruhf, Wine and Beer

Branch, Bureau of Alcohol, Tobacco and Firearms, 650 Massachusetts Avenue NW., Washington, DC 20226 (202-927-8230).

SUPPLEMENTARY INFORMATION:**Background**

On August 23 and November 22, 1978, ATF published Treasury Decision ATF-53 (43 FR 37672, 54624) revising regulations in 27 CFR Part 4. These regulations allow the establishment of definite American viticultural areas. The regulations also allow the name of an approved viticultural area to be used as an appellation of origin in the labeling and advertising of wine.

On October 2, 1979, ATF published Treasury Decision ATF-60 (44 FR 56692) which added a new part 9 to 27 CFR, providing for the listing of approved American viticultural areas. Section 4.25(e)(1), title 27, CFR, defines an American viticultural area as a delimited grape-growing region distinguishable by geographical features, the boundaries of which have been delineated in subpart C of part 9. Section 4.25(e)(2) outlines the procedure for proposing an American viticultural area. Any interested person may petition ATF to establish a grape-growing region as a viticultural area. The petition should include:

(a) Evidence that the name of the proposed viticultural area is locally and/or nationally known as referring to the area specified in the petition;

(b) Historical or current evidence that the boundaries of the viticultural area are as specified in the petition;

(c) Evidence relating to the geographical features (climate, soil, elevation, physical features, etc.) which distinguish the viticultural features of the proposed area from surrounding areas;

(d) A description of the specific boundaries of the viticultural area, based on features which can be found on United States Geological Survey (U.S.G.S.) maps of the largest applicable scale; and

(e) A copy of the appropriate U.S.G.S. map(s) with the boundaries prominently marked.

Petition

ATF has received a petition from Marston Vineyards and York Creek Vineyards proposing to establish a viticultural area in Napa County, California, to be known as "Spring Mountain." The proposed viticultural area is located within Napa Valley just west of St. Helena, on the eastern slope of the Mayacamas Mountains that separate Napa Valley from Sonoma Valley and the Santa Rosa Plain.

The region is approximately 25 miles north of San Pablo Bay and 30 miles east of the Pacific Ocean. It contains approximately 8,600 acres, of which approximately 800 acres are planted to vineyards. The terrain in the proposed viticultural area consists primarily of east-facing slopes of varying steepness, ranging in elevation from 400 to 2,600 feet. Thirteen wineries are currently active within the proposed viticultural area.

Evidence of Name

Evidence that the name of the proposed area is locally and/or nationally known as referring to the area specified in the petition includes:

(a) Articles in the local newspaper, the St. Helena Star, as far back as December 1877, frequently made references to "Spring Mountain" and mentioned viticultural activities in the area.

(b) In the Annual Report of State Viticultural Commissioners for 1887, on the page that listed varieties of grapes planted in Napa County, "Spring Mountain" was 1 of only 12 locations mentioned.

(c) In California Place Names by Erwin G. Gudde, 3rd Ed. (University of California Press, 1969), Spring Mountain is described as a region filled with reservoirs which supplied water to the town of St. Helena from 1878 to the 1920's. Further, "Spring Mountain" was the name of the school that educated children in the area from the 1870's to the 1930's, and is the name of the principal road that runs through the proposed viticultural area.

(d) In Massee's Guide to Wines of America (1974) "Spring Mountain" is described as being "well on its way to becoming a separate district in its own right, much like Carneros." * * *

(e) Copies of wine labels (1980 Ritchie Creek Vineyard Cabernet Sauvignon, 1978 and 1981 Ridge Cabernet Sauvignon, 1978 and 1986 Ridge Petite Sirah), each of which indicates that most of the grapes used to make the wine came from Spring Mountain.

(f) As stated in the January-February 1977 issue of Connoisseur's Guide to California Wines, "Spring Mountain * * * has supported vineyards for over 100 years and is probably more responsible than any other Napa hillside for creating the mystique of 'mountain grapes.'" * * *

(g) An excerpt from an article appearing in the magazine Friends of Wine (April-May 1984) makes a reference to "Spring Mountain" as being a "well-known" appellation.

Evidence of Boundaries

Evidence that the boundaries of the proposed area are as specified in the petition includes the following:

(a) In the Annual Report of the Board of State Viticultural Commissioners for 1887, Spring Mountain is listed as one of the locations in Napa County where varieties of grapes were planted.

(b) In *The Connoisseurs' Handbook of California Wines* (1984) the section on "Wine Geography" describes Spring Mountain as "[a] distinctly identifiable watershed area * * * west of St. Helena in the Napa Valley and forms part of the Mayacamas Mountain Range * * * Chateau Chevalier and Spring Mountain Vineyard occupy two of the loveliest refurbished properties * * * York Creek Vineyard is near the top of Spring Mountain. Other wineries here include Yverdon, Keenan, and Smith-Madrone."

(c) In the book *The Wineryrights Register* (1988) Spring Mountain is described as being "directly west of the town of St. Helena."

(d) In the New Signet Book of Wine (1985) Alexis Bessaloff states that a "number of wineries are situated on the slopes of Spring Mountain, the best known of which is Spring Mountain Vineyards." Other vineyards and wineries mentioned as "situated on the slopes of Spring Mountain" include Newton Vineyard, Chateau Chevalier, Cain Cellars, Robert Keenan Winery, Yverdon Vineyards, Ritchie Creek Vineyard, and Smith-Madrone Vineyards.

(e) In Leon D. Adams' *The Wines of America* (1978) Chateau Chevalier winery is described as being "built in 1891 on Spring Mountain * * *"

(f) In *The 1982 Napa Valley Wine Auction* catalog Keenan Winery is described as "located * * * on the eastern slope of Spring Mountain," and Chateau Chevalier, and Smith-Madrone Vineyards are described as being "high atop Spring Mountain."

(g) Labels for 1978 and 1981 Ridge brand Cabernet Sauvignon indicate that part of the wine came from grapes grown at York Creek Vineyards "on Spring Mountain."

(h) In California's Great Cabernets (1989) Spring Mountain is described as including the vineyards of York Creek, Smith-Madrone, Philip Togni, and Newton.

(i) In *Masse's Guide to Wines of America* (1974) Lyncrest Vineyard, currently Marston Vineyards, is also mentioned in the paragraph on Spring Mountain.

(j) In Bob Thompson's *Pocket Guide to California Wines* (1990) Streblov Vineyards is described as "[a] 12-acre

vineyard and 1,200 case winery on the lower slopes of Spring Mountain * * * and Spring Mountain is said to be the "sole source of all the wines" for Stony Hill Vineyards.

Collectively taken, the locations of the vineyards and wineries mentioned above closely approximate the parameters of the proposed Spring Mountain viticultural area.

Geographical Features

Approximately 8,600 acres in size, the proposed viticultural area is roughly rectangular in shape, extending south from the northern boundary along Ritchie Creek approximately 5 miles to slightly beyond Sulphur Creek, and east from the Napa-Sonoma county line along the summit of the Mayacamas mountain range to the 400 foot elevation near the Napa Valley floor. The 400 foot contour line generally marks the boundary between valley floor and hillside vineyards in the Napa Valley. The petitioners provided the following evidence relating to features which they contend distinguish the proposed viticultural area from the surrounding areas:

Soil

(a) The predominant soils in the proposed Spring Mountain viticultural area consist of moderately deep and deep residual upland soils that are an equal mix derived from volcanic and sedimentary parent material.

(b) North of the proposed viticultural area the segment of the Mayacamas Mountains from Diamond Mountain northward is comprised almost entirely of residual upland soils of volcanic origins.

(c) To the east of the proposed viticultural area, on the Napa Valley floor, alluvial soils predominate. These soils are developed on fill materials outwashed from the upland soils and rocks surrounding the valley. The Soil Conservation Service has identified 10 alluvial soils in the valley, none of which are found in the proposed viticultural area.

(d) Of the six residual upland soils from volcanic rocks that are present in the proposed viticultural area (Aiken, Boomer, Felta, Forward, Hambricht, and Kidd), only one (Forward) appears in any significant acreage to the south of the proposed Spring Mountain. Both areas contain residual soils from sedimentary rocks, but the acreage and percentage of these sedimentary residual rocks is much greater in the southern segment of the Mayacamas Mountains, south of the proposed Spring Mountain.

(e) West of the proposed viticultural area the warmer slopes of the Mayacamas Mountains in Sonoma County have greater evapotranspiration loss of soil moisture, which is reflected in shallower soils. Also, the residual upland soils from volcano rock found in the proposed viticultural area (Aiken, Boomer, Forward, Felta, and Kidd) are not present in the Sonoma County slopes of the Mayacamas Mountains.

Climate

(a) Spring Mountain's primarily eastern exposure contributes to the region's distinctive climate. It is characterized by cool, wet winters and warm dry summers, moderated by periodic ocean breezes and fog. Average annual rainfall is 37 inches.

(b) In readings taken between April 1 and October 31, generally considered the growing season for wine grapes, daily maximum temperatures were from 2 to 11 degrees lower within the proposed viticultural area than in St. Helena, less than 4 miles away to the east. Conversely, daily minimum temperatures at Spring Mountain were generally higher than those recorded in St. Helena, often by more than 10 degrees.

(c) Comparisons of maximum and minimum temperatures within the proposed viticultural area with those of Calistoga, less than 8 miles away to the north, produce the same results, with even greater temperature differentials between the two locations.

(d) The proposed viticultural area regularly enjoys cooling breezes and occasional fog from the west when the rest of Napa Valley, including hillside locations both north and south remains hot.

(e) Spring Mountain experiences greater annual rainfall than the floor of Napa Valley. In addition, the annual average rainfall in Spring Mountain is approximately 37 inches, more than the seasonal normal of 33.11 inches in St. Helena.

(f) According to meteorologist Steven Newman of Earth Environment Service, a review of daily thermograph readings taken during the summer and early autumn shows that the temperature on Spring Mountain rises relatively rapidly until reaching a maximum high at approximately 3 p.m., then declines with similar speed during the late afternoon. The daily maximum temperature is reached approximately 1 hour earlier than in St. Helena, and the temperature peak is very brief when compared to locations on the Napa Valley floor.

Proposed Boundary

The boundary of the proposed Spring Mountain viticultural area may be found on four United States Geological Survey (U.S.G.S.) maps with a scale of 1:24000. The boundary is described in § 9.145.

Executive Order 12291

It has been determined that this proposed regulation is not a major regulation as defined in Executive Order 12291 and a regulatory impact analysis is not required because it will not have an annual effect on the economy of \$100 million or more; it will not result in a major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; and it will not have significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

Regulatory Flexibility Act

It is hereby certified that this regulation will not have a significant economic impact on a substantial number of small entities. Accordingly, a regulatory flexibility analysis is not required because the proposal, if promulgated as a final rule, is not expected (1) to have secondary, or incidental effects on a substantial number of small entities; or (2) to impose, or otherwise cause a significant increase in the reporting, recordkeeping, or other compliance burdens on a substantial number of small entities.

Paperwork Reduction Act

The provisions of the Paperwork Reduction Act of 1980, Public Law 96-511, 44 U.S.C. chapter 35, and its implementing regulations, 5 CFR part 1320, do not apply to this notice of proposed rulemaking because no requirement to collect information is proposed.

Public Participation

ATF requests comments from all interested parties. Comments received on or before the closing date will be carefully considered. Comments received after that date will be given the same consideration if it is practical to do so, but assure of consideration cannot be given except as to comments received on or before the closing date.

ATF will not recognize any comment as confidential. Comments may be disclosed to the public. Any material which a commenter considers to be confidential or inappropriate for disclosure to the public should not be

included in the comment. The name of the person submitting a comment is not exempt from disclosure. During the comment period, any person may request an opportunity to present oral testimony at a public hearing. However, the Director reserves the right to determine, in light of all circumstances, whether a public hearing will be held.

Drafting Information

The principal author of this document is Marjorie D. Ruhf, Wine and Beer Branch, Bureau of Alcohol, Tobacco and Firearms.

List of Subjects in 27 CFR Part 9

Administrative practice and procedure, Consumer protection, Viticultural areas, and Wine.

Authority and Issuance

Accordingly, title 27, Code of Federal Regulations, part 9, American Viticultural Areas, is proposed to be amended as follows:

PART 9—AMERICAN VITICULTURAL AREAS

1. The authority citation for part 9 continues to read as follows:

Authority: 27 U.S.C. 205.

2. Subpart C is amended by adding § 9.143 to read as follows:

Subpart C—Approved American Viticultural Areas

§ 9.143 Spring Mountain.

(a) *Name.* The name of the viticultural area described in this section is "Spring Mountain."

(b) *Approved maps.* The appropriate maps for determining the boundary of the Spring Mountain viticultural area are four U.S.G.S. 7.5 minute series topographical maps of the 1:24000 scale. They are titled:

- (1) "Kenwood, Calif.," 1954 (photorevised 1980);
- (2) "Rutherford, Calif.," 1951 (photorevised 1968);
- (3) "St. Helena, Calif.," 1960 (photorevised 1980);
- (4) "Calistoga, Calif.," 1958 (photorevised 1980).

(c) *Boundary.* The Spring Mountain viticultural area is located in Napa County, California, within the Napa Valley Viticultural area. The boundary is as follows:

- (1) Beginning on the Calistoga quadrangle map at the Napa-Sonoma county line at the boundary line between sections 18 and 19 in T8N/R6W;
- (2) Then east along the boundary line between sections 18 and 19 for approximately $\frac{3}{4}$ of a mile to its

intersection with Ritchie Creek at the boundary line between sections 17 and 20;

(3) Then northeast along Ritchie Creek approximately 2 miles, to the 400 foot contour line in the northeast corner in section 16 of T8N/R6W;

(4) Then along the 400 foot contour line in a northeast then generally southeast direction, through the St. Helena and Rutherford quadrangle maps, approximately 9 miles, past the town of St. Helena to the point where it intersects Sulphur Creek in Sulphur Canyon, in the northwest corner of section 2 in T7N/R6W;

(5) Then west along Sulfur Creek (onto the Kenwood quadrangle map) and south to the point where it first divides into two intermittent streams in section 3 in T7N/R6W;

(6) Then south along the intermittent stream approximately 1.5 miles to the point where it intersects the 2,360 foot contour line in section 10 in T7N/R6W;

(7) Then southwest in a straight line, approximately .10 mile, to the unnamed peak (elevation 2600 feet) at the boundary line between Napa and Sonoma Counties;

(8) Then in a generally northwest direction along the Napa-Sonoma county line, through sections 10, 9, 4, 5, 32, 33, 32, 29, 20, and 19, to the beginning point on the Calistoga quadrangle map at the boundary between sections 18 and 19 in T8N/R6W.

Approved: May 21, 1992

Stephen Higgins,
Director.

[FR Doc. 92-12916 Filed 6-3-92; 8:45 am]

BILLING CODE 4810-31-M

DEPARTMENT OF TRANSPORTATION

Coast Guard

33 CFR Part 165

[CGD1 92-004]

Safety Zone: Rhode Island Sound, Narragansett Bay, Providence River

AGENCY: Coast Guard, DOT.

ACTION: Notice of proposed rulemaking.

SUMMARY: The Coast Guard proposes to amend the regulation concerning the safety zone required around LPG vessels moored at the LPG facility in the Port of Providence. The amendment would reduce the distance a vessel must moor from an LPG vessel at the LPG facility in the Port of Providence from 400 feet to 200 feet. This action is necessary to eliminate unnecessary economic hardship on the commercial shipping

industry. Reduction of the required empty pier space from 400 feet to 200 feet fore and aft of LPG vessels will continue to provide the necessary level of safety and will also provide the space necessary to respond effectively to an LPG emergency.

DATES: Comments must be received on or before July 20, 1992.

ADDRESSES: Comments should be mailed to the Commanding Officer, Marine Safety Office, John O'Pastore Federal Building, Providence, Rhode Island 02903-1790, or may be delivered to room 217 at the above address between 7:30 a.m. and 4 p.m., Monday through Friday, except Federal holidays. The telephone number is (401) 528-5335. The Marine Safety Office maintains the public docket for this rulemaking. Comments will become part of this docket and will be available for inspection or copying at room 217, Marine Safety Office Providence.

FOR FURTHER INFORMATION CONTACT: LTJG Tina Burke at (401) 528-5335.

SUPPLEMENTARY INFORMATION:

Request for Comments

The Coast Guard encourages interested persons to participate in this rulemaking by submitting written data, views, or arguments. Persons submitting comments should include their name and address, identify this rulemaking (CGD1 92-004) and the specific section of this proposal to which each comment applies, and give a reason for each comment. Persons wanting acknowledgment of receipt of comments should enclose a stamped, self-addressed postcard or envelope.

The Coast Guard will consider all comments received during the comment period and may change this proposal in view of the comments.

The Coast Guard plans no public hearing. Persons may request a public hearing by writing to the Marine Safety Office at the address under "ADDRESSES." If it determines that the opportunity for oral presentations will aid this rulemaking, the Coast Guard will hold a public hearing at a time and place announced by a later notice in the Federal Register.

Drafting Information

The principal persons involved in drafting this document are LTJG Tina Burke, Project Officer, Marine Safety Office Providence, and LCDR J. Astley, Project Counsel, First Coast Guard District Legal Office.

Background and Purpose

The regulations contained in 33 CFR 165.121 outline safety zones required for

LPG vessel visiting the Port of Providence under a variety of conditions. The regulations establish safety zones around LPG vessels at anchor, transiting Narragansett Bay, while moored at the LPG facility, Port of Providence, and around the shoreside manifold during LPG transfer operations. The proposed amendment only concerns the safety zone required around LPG vessels moored at the LPG facility, Port of Providence.

33 CFR 165.121(a)(3) establishes a 50 foot safety zone around a moored LPG vessel and also requires that no vessel may moor within 400 feet of an LPG vessel moored at the facility. Industry personnel have continually expressed dissatisfaction with the 400 foot requirement, contending that it places an unnecessary economic burden on the industry involved in and affected by LPG evolutions.

Research into the issue has shown that prohibiting vessels from mooring within 400 feet from LPG vessels moored at the LPG facility, Port of Providence, is excessive and unnecessary. The purpose of requiring that other vessels moor a certain distance from LPG vessels is to eliminate risk of ignition sources as well as to ensure the availability of space around the vessel to respond to any type of emergency. The safety zone established around a vessel when moored at the facility is 50 feet. Thus the vessel is considered safe from ignition sources at a minimum of 50 feet. A 50 foot zone is not sufficient, however, in the event that a vessel needs to be moved in response to an emergency. Therefore, reduction of the requirement from 400 feet to 200 feet would continue to provide ignition source protection and would also provide the space necessary for shoreside or waterside firefighting or for tug assistance during emergency break-away from the pier.

Regulatory Evaluation

This proposal is not major under Executive Order 12291 and not significant under the Department of Transportation Regulatory Policies and Procedures (44 FR 11040; February 26, 1979). The Coast Guard expects the economic impact of this proposal to be so minimal that a Regulatory Evaluation is unnecessary. The Coast Guard expects the impact of this proposal to be minimal on all entities because the result of the amendment will be one of deregulation, making the present regulations less restrictive. If the amendment has any effect, it will be a positive effect on impacted entities. Reduction of the safety zone around moored LPG vessels from 400 feet to 200 feet will benefit the LPG facility

economically in that the total pierspace for which they must pay to meet the regulations is reduced from a total of 800 feet to 400 feet. This will also benefit the port of Providence economically in that more pierspace will be available for other ships to moor while an LPG vessel is in port.

Small Entities

Under the Regulatory Flexibility Act (5 U.S.C. 601 et seq.), the Coast Guard must consider whether this proposal will have a significant economic impact on a substantial number of small entities. "Small entities" include independently owned and operated small businesses that are not dominant in their field and that otherwise qualify as "small business concerns" under section 3 of the Small Business Act (15 U.S.C. 632).

For the reasons outlined in the Regulatory Evaluation, the Coast Guard expects that this proposal will not have a significant economic impact on any entity. Therefore, the Coast Guard certifies under 5 U.S.C. 605(b) that this proposal, if adopted, will not have a significant economic impact on a substantial number of small entities. If, however, you think that your business qualifies as a small entity and that this proposal will have a significant economic impact on your business, please submit a comment (see "ADDRESSES") explaining why you think your business qualifies and in what way and to what degree this proposal will economically affect your business.

Collect of Information

This proposal contains no collection of information requirements under the Paperwork Reduction Act (44 U.S.C. 3501 et seq.)

Federalism

The Coast Guard has analyzed this proposal in accordance with the principles and criteria contained in Executive Order 12612 and has determined that this proposal does not have sufficient federalism implications to warrant the preparation of a Federalism Assessment.

Environment

The Coast Guard considered the environmental impact of this proposal and concluded that under section 2.B.2.C of Commandant Instruction M16475.1B, this proposal is categorically excluded from further environmental documentation. A Categorical Exclusion Determination is available in the docket for inspection or copying where indicated under "ADDRESSES."

List of Subjects in 33 CFR Part 165

Harbors, Marine safety, Navigation (water), Security measures, Vessels, Waterways.

Proposed Regulations

In consideration of the foregoing, part 165 of Title 33, Code of Federal Regulations, is proposed to be amended as follows:

PART 165—[AMENDED]

1. The authority citation for part 165 continues to read as follows:

Authority: 33 U.S.C. 1231; 50 U.S.C. 191; 49 CFR 1.46 and 33 CFR 1.05-1(g), 6.04-1, 6.04-6, and 160.5.

2. Section 165.121 is amended by revising paragraph (a)(3) to read as follows:

§ 165.121 **Safety Zone: Rhode Island Sound, Narragansett Bay, Providence River.**

(a) * * *

(3) For Liquefied Petroleum Gas (LPG) vessels while moored at the LPG facility, Port of Providence; a Safety Zone within 50 feet around the vessel. No vessel shall moor within 200 feet from the LPG vessel. All vessels transiting the area are to proceed with caution to minimize the effects of wake around the LPG vessel.

* * *
Dated: May 18, 1992.

H.D. Robinson,
Captain, U.S. Coast Guard, Captain of the Port, Providence, RI.

[FR Doc. 92-12938 Filed 6-3-92; 8:45 am]

BILLING CODE 4910-14-M

FEDERAL MARITIME COMMISSION**46 CFR Parts 510, 580 and 582**

[Docket No. 92-27]

Filing Requirements for Anti-Rebate Certifications

AGENCY: Federal Maritime Commission.

ACTION: Proposed rule.

SUMMARY: The Federal Maritime Commission proposed to amend its regulations which govern certification of freight forwarder and carrier policies and efforts to combat rebating in the foreign commerce of the United States. The proposed amendments will reduce the annual certification filing requirement to every two years. The intent of this proposal is, without loss of regulatory effectiveness, to reduce the cost imposed on regulated companies by these regulations and to reduce the cost incurred by the Commission in administering them.

DATES: Comments due July 6, 1992.

Comments must be received at the Commission by the due date; the date of mailing will not be accepted as the date of filing in this proceeding.

ADDRESSES: Comments (original and 15 copies) are to be submitted to: Joseph C. Polking, Secretary, Federal Maritime Commission, 1100 L Street, NW., Washington, DC 20573, (202) 523-5725.

FOR FURTHER INFORMATION CONTACT: Seymour Glazer, Director, Bureau of Hearing Counsel, Federal Maritime Commission, 1100 L Street, NW., Washington, DC 20573, (202) 523-5783 (Phone), (202) 523-5785 (FAX).

SUPPLEMENTARY INFORMATION:**Background**

Section 15 of the Shipping Act of 1984 ("1984 Act"), 46 U.S.C. app. 1714, mandates that the Federal Maritime Commission ("Commission") require the Chief Executive Officer ("CEO") of each common carrier to file with the Commission a written anti-rebating certification ("ARC") under oath. Section 15 also authorizes the Commission to require the CEO of ocean freight forwarder to file ARCs under oath.

Part 582 of the Commission's rules, 46 CFR part 582, implements section 15 of the 1984 Act by establishing the content of ARCs and procedures governing their filing. Under part 582, the CEO of a common carrier in the foreign commerce of the United States must file an ARC with the Commission on or before December 31 of each year. Part 580, 46 CFR at 580.5(c)(2)(ii), governs tariff requirements regarding ocean carriers' ARCs.

Similarly, part 510 of the Commission's rules, at 46 CFR 510.25, requires licensed ocean freight forwarders to file ARCs on or before December 31 of each year. The content of freight forwarders' ARCs and the procedures for filing them is governed by part 582, *supra*.

Section 15 of the 1984 Act also provides that whoever fails to file an ARC required by the Commission is liable to the United States for a civil penalty of not more than \$5,000 for each day the violation continues.

The Commission proposes to amend parts 510, 580 and 582 of its rules to require ARCs be filed every two years rather than annually. If this proposal becomes final, appropriate changes also will be made to the final rule promulgated at 46 CFR 514, implementing the Commission's automated tariff filing and information system. See e.g. § 514.1(c)(1)(iii) of the September 9, 1991, Proposed Rule in

FMC Docket No. 90-23 Tariffs and Service Contracts (56 FR 46055). This should reduce the administrative and cost burdens on the regulated industry, as well as on the Commission, without causing any appreciable loss of regulatory effectiveness.

For administrative consistency, the proposed rule requires that ARCs be filed by December 31 of each even-numbered year. (The proposed rule also makes technical changes to reflect the redesignation of the Commission's Bureau of Domestic Regulation as the Bureau of Tariffs, Certification and Licensing.)

Although the Commission, as an independent regulatory agency, is not subject to Executive Order 12291, dated February 17, 1981, it nonetheless has reviewed the rule in terms of that Order and has determined that this rule is not a "major rule" as defined in Executive Order 12291 because it will not result in:

(1) Annual effect on the economy of \$100 million or more;

(2) A major increase in costs or prices for consumers, individual industries, Federal, State or local government agencies, or geographic regions; or

(3) Significant adverse effects on competition, employment, investment, productivity, innovations, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

The Federal Maritime Commission certifies, pursuant to section 605(b) of the Regulatory Flexibility Act, 5 U.S.C. 605(b), that this rule will not have a significant economic impact on a substantial number of small entities, including small businesses, small organizational units and small government jurisdictions.

This proposed rule does not contain any collection of information requirements that require submission to the Office of Management and Budget ("OMB"). Therefore, OMB review is not required.

List of Subjects**46 CFR Part 510**

Freight forwarders, Maritime carriers, Reporting and recordkeeping requirements, Surety bonds.

46 CFR Part 580

Freight, Maritime carriers, Reporting and recordkeeping requirements.

46 CFR Part 582

Maritime carriers, Penalties, Reporting and recordkeeping requirements.

Therefore, pursuant to 5 U.S.C. 553 and section 15 and 19 of the Shipping Act of 1984, 46 U.S.C. app. 1714 and 1718, parts 510, 580 and 582 of title 46, Code of Federal Regulations, are proposed to be amended as follows:

PART 510—[AMENDED]

1. The authority citation for Part 510 continues to read as follows:

Authority: 5 U.S.C. 553, 46 U.S.C. app. 1702, 1707, 1709, 1710, 1712, 1714, 1716 and 1718; 21 U.S.C. 853a.

2. Section 510.25 is revised to read as follows:

§ 510.25 Anti-rebate certifications.

(a) Every licensed ocean freight forwarder shall file an anti-rebating certificate on or before December 31, 1992 and, thereafter, on or before December 31 of each succeeding even-numbered calendar year.

(b) Every applicant for an ocean freight forwarder license shall file an anti-rebating certificate with its license application. Any application for an ocean freight forwarder license that does not include an anti-rebate certification in accordance with § 510.12 and part 582 of this chapter shall be rejected. Certificates filed with license applications shall be valid from the granting of an ocean freight forwarder license through the first succeeding December 31 of an even-numbered calendar year.

(c) The anti-rebating certificate shall comply with the requirements of part 582 of this chapter.

PART 580—[AMENDED]

3. The authority citation for part 580 continues to read as follows:

Authority: 5 U.S.C. 553; 46 U.S.C. app. 1702-1705, 1707, 1709, 1710-1712, 1714-1716, 1718, and 1722.

4. Section 580.5(c)(2)(ii)(B) is revised to read as follows:

§ 580.5 Tariff contents.

• • • • •

(c) • • •

(2) • • •

(ii) • • •

(B) In addition to the anti-rebate tariff provision, an anti-rebating certificate shall be filed by every common carrier with its initial tariff, and thereafter, on each succeeding December 31 of an even-numbered calendar year. The anti-rebating certificate shall comply with the requirements of part 582 of this chapter. Failure of a common carrier to file an anti-rebate certification with initial tariffs and publish notice of that certification in its tariff as required by

this part and part 582 of this chapter shall result in rejection of that carrier's tariff. Any common carrier who fails to file an anti-rebate certification as required by part 582 of this chapter will be notified by Federal Register publication and by certified mail that if within forty-five (45) days from the date the certified notice is mailed the common carrier does not either establish that the required anti-rebate certification was filed in accordance with this part and part 582 of this chapter or file the required anti-rebate certification, its tariff will be canceled, and in the event its rates are published in one or more conference tariffs, its name will be stricken from the list of carriers participating in those conference tariffs. The tariff(s) of any common carrier who files an anti-rebate certification after December 31 but before the end of the forty-five (45) days notice period will not be canceled; however, the common carrier will be subject to civil penalties as provided in part 582 of this chapter. After the forty-five (45) days, any common carrier that does not have an anti-rebate certification on file with the Commission will be notified by Federal Register publication and certified mail, return receipt requested, that its tariff(s) have been canceled or its name has been stricken from conference tariff(s).

PART 582—[AMENDED]

5. The authority citation for part 582 continues to read as follows:

Authority: 5 U.S.C. 553; 46 U.S.C. app. 1701, 1702, 1707, 1709, 1712 and 1714-1716.

6. Section 582.3 is revised to read as follows:

§ 582.3 Reporting requirements.

(a) Every common carrier required by this part to file a written certification in the form prescribed by § 582.2, shall file such certification with its initial tariff and, thereafter, on or before December 31 of each succeeding even-numbered calendar year.

(b) Every licensed ocean freight forwarder, required by § 510.25 of this chapter to file a written certification in the form prescribed by § 582.2, shall file such certification on or before December 31, 1992 and, thereafter, on or before December 31 of each succeeding even-numbered calendar year. Every applicant for an ocean freight forwarder license initially shall file such certification with its license application.

(c) The certification required by this section shall be valid from the initial filing of a tariff or granting of an ocean

freight forwarder license through the first succeeding December 31 of an even-numbered calendar year.

(d) Every person other than a common carrier or ocean freight forwarder which is ordered by the Commission pursuant to § 582.2 to file a written certification shall file such certification in the manner prescribed by the Commission.

(e) In those instances in which a single firm operates in more than one capacity, such as both a non-vessel-operating common carrier and an ocean freight forwarder, a single certificate may be submitted to satisfy the reporting requirements of this section.

Joseph C. Polking,

Secretary.

[FR Doc. 92-13035 Filed 6-3-92; 8:45 am]

BILLING CODE 6730-01-M

46 CFR Parts 520, 550 and 580

[Docket No. 92-26]

Filing of Tariffs by Terminal Barge Operators in Pacific Slope States—Notice of Proposed Rulemaking

AGENCY: Federal Maritime Commission.

ACTION: Notice of proposed rulemaking.

SUMMARY: The Federal Maritime Commission proposes to remove 46 CFR part 520—Filing of Tariffs by Terminal Barge Operators in Pacific Slope States and to amend 46 CFR parts 550 and 580 to exempt certain marine terminal barge operators from the tariff filing requirements of the Shipping Act, 1916, and the Shipping Act of 1984. This action is being proposed because there no longer appears to be a regulatory need for part 520.

DATES: Comments on or before July 6, 1992. Comments must be received at the Commission by the due date; the date of mailing will not be accepted as the date of filing in this proceeding.

ADDRESSES: Comments (original and 15 copies) are to be submitted to: Joseph C. Polking, Secretary, Federal Maritime Commission, 1100 L Street, NW., Washington, DC 20573, (202) 523-5725.

FOR FURTHER INFORMATION CONTACT: Bryant L. VanBrakle, Director, Bureau of Tariffs, Certification and Licensing, Federal Maritime Commission, 1100 L Street, NW., Washington, DC 20573, (202) 523-5796.

SUPPLEMENTARY INFORMATION:

Background

The Federal Maritime Commission ("Commission") administers, *inter alia*, section 3 of the Shipping Act, 1916 ("1916 Act"), 46 U.S.C. app. 804

("Section 3"). Section 3 requires the filing of tariffs by terminal barge operators who meet several very specific criteria.¹ Section 3 was added to the 1916 Act to clarify the jurisdictional roles of the Commission and the Interstate Commerce Commission concerning barge movements on one particular inland waterway.

The Commission's regulations implementing section 3 are at 46 CFR part 520. In general terms, section 3 and these regulations require tariffs to be filed by terminal barge operators in Pacific Slope States moving containers or containerized cargo by barge between points in the United States, on the one hand, and points in foreign countries or non-contiguous political jurisdictions of the United States, on the other.²

The Commission now proposes to remove 46 CFR part 520 and to amend 46 CFR parts 550 and 580 to exempt terminal barge operators in Pacific Slope States from filing tariffs for the services provided under the conditions set forth in Section 3.³

Title 46 CFR part 520 has been in effect since 1975. There is, however, no record of any recent filing of tariffs pursuant to these regulations. The Commission believes, therefore, that it would be appropriate to remove part 520

and to provide an exemption under parts 550 and 580 with regard to the requirement to file tariffs with the Commission.

Section 35 of the 1916 Act, 46 U.S.C. app. 833a, and section 16 of the Shipping Act of 1984 ("1984 Act"), 46 U.S.C. app. 1715, provide that the Commission may by order or rule exempt for the future any specified activity of persons subject to the 1916 Act or the 1984 Act from any requirement of the 1916 Act, the 1984 Act, or Intercoastal Shipping Act, 1933, where the Commission finds that such exemption will not substantially impair effective regulation by the Commission, be unjustly discriminatory, result in a substantial reduction in competition (1984 Act only) or be detrimental to commerce. It appears that the proposed exemptions would meet these criteria.

Although the Commission, as an independent regulatory agency, is not subject to Executive Order 12291, dated February 17, 1981, it nonetheless has reviewed the rule in terms of this Order and has determined that this rule is not a "major rule" because it will not result in:

- (1) An annual effect on the economy of \$100 million or more;
- (2) A major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or
- (3) Significant adverse effect on competition, employment, investment, productivity, innovations, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

The Federal Maritime Commission certifies, pursuant to section 605(b) of the Regulatory Flexibility Act, 5 U.S.C. 605(b), that this Proposed Rule, if adopted, will not have a significant economic impact on a substantial number of small entities, including small businesses, small organizational units, and small governmental organizations.

This proposed rule does not contain any collection of information requirements as defined by the Paperwork Reduction Act of 1980, as amended. Therefore, OMB review is not required.

List of Subjects

46 CFR Part 520

Freight, Maritime carriers, Reporting and recordkeeping requirements.

46 CFR Part 550

Maritime carriers; Reporting and recordkeeping requirements.

46 CFR Part 580

Cargo, Cargo vessels; Freight; Exports; Harbors; Imports; Maritime carriers, Rates; Reporting and recordkeeping requirements; Surety bonds; Water carriers; Water transportation.

Therefore, pursuant to 5 U.S.C. 553; sections 3, 18(a) and 43 of the Shipping Act, 1916, 46 U.S.C. app. 804, 817(a) and 841a; section 2 of the Intercoastal Shipping Act, 1933, 46 U.S.C. app. 844; and sections 8, 10, 11, 12, 13, 17 and 23 of the Shipping Act of 1984, 46 U.S.C. app. 1707, 1709, 1710, 1711, 1712, 1716 and 1722; parts 520, 550 and 580 of title 46 of the Code of Federal Regulations are proposed to be amended as follows:

PART 520—[REMOVED]

Part 520 is removed.

PART 550—[AMENDED]

1. The authority citation for part 550 continues to read as follows:

Authority: 5 U.S.C. 553; 46 U.S.C. app. 812, 814, 815, 817, 820, 833a, 841a, 843, 844, 845, 854a, 845b, and 847.

2. Section 550.1(a)(10) is added to read as follows:

§ 550.1 Exemptions.

(a) * * *

(10) Transportation provided by terminal barge operators in Pacific Slope States barging containers and containerized cargo by barge between points in the United States where:

(i) The cargo is moving between a point in a foreign country or a non-contiguous State, territory, or possession and a point in the United States;

(ii) The transportation by barge between points in the United States is furnished by a terminal operator as a service substitute in lieu of a direct vessel call by the common carrier by water transporting the containers or containerized cargo under a through bill of lading; and

(iii) Such terminal operator is a Pacific Slope State, municipality, or other public body or agency subject to the jurisdiction of the Federal Maritime Commission, and the only one furnishing the particular circumscribed barge service in question as of January 2, 1975.

PART 580—[AMENDED]

1. The authority citation for part 580 continues to read as follows:

Authority: 5 U.S.C. 553; 46 U.S.C. app. 1702-1705, 1707, 1709, 1710-1712, 1714-1716, 1718, and 1722.

¹ Section 3 provides, in pertinent part:

Notwithstanding part III of the Interstate Commerce Act, as amended (49 U.S.C. 901 *et seq.*), or any other provision of law, rates and charges for the barging and affreighting of containers and containerized cargo by barge between points in the United States, shall be filed solely with the Federal Maritime Commission in accordance with rules and regulations promulgated by the Commission where (a) the cargo is moving between a point in a foreign country or a non-contiguous State, territory, or possession and a point in the United States, (b) the transportation by barge between points in the United States is furnished by a terminal operator as a service substitute in lieu of a direct vessel call by the common carrier by water transporting the containers or containerized cargo under a through bill of lading, (c) such terminal operator is a Pacific Slope State, municipality, or other public body or agency subject to the jurisdiction of the Federal Maritime Commission, and the only one furnishing the particular circumscribed barge service in question as of the date of enactment hereof, and (d) such terminal operator is in compliance with the rules and regulations of the Federal Maritime Commission for the operation of such barge service. The terminal operator providing such services shall be subject to the provisions of the Shipping Act, 1916.

² The Commission's regulations for the filing of tariffs in the domestic offshore commerce of the United States are at 46 CFR part 550, while the regulations for tariffs in the foreign commerce are at 46 CFR part 580.

³ Should this proposed exemption become a Final Rule, it will be incorporated into new part 514, which, when finalized, will provide for the Automated Tariff Filing and Information system. See §§ 514.1(c)(3)(ii) and 514.3(a)(7) of the Proposed Rule of September 9, 1991, 56 FR 46055 and 46081.

2. Section 580.1(c)(9) is added to read as follows:

§ 580.1 Exemptions and exclusions.

(c) * * *

(9) Transportation provided by terminal barge operators in Pacific Slope States barging containers and containerized cargo by barge between points in the United States where:

(i) The cargo is moving between a point in a foreign country or a non-contiguous State, territory, or possession and a point in the United States;

(ii) The transportation by barge between points in the United States is furnished by a terminal operator as a service substitute in lieu of a direct vessel call by the common carrier by water transporting the containers or containerized cargo under a through bill of lading; and

(iii) Such terminal operator is a Pacific Slope State, municipality, or other public body or agency subject to the jurisdiction of the Federal Maritime Commission, and the only one furnishing the particular circumscribed barge service in question as of January 2, 1975.

By the Commission.

Joseph C. Polking,
Secretary.

[FR Doc. 92-13034 Filed 6-3-92; 8:45 am]

BILLING CODE 6730-01-M

46 CFR Parts 550 and 580

[Docket No. 92-28]

Elimination of Certain Regulatory Provisions

AGENCY: Federal Maritime Commission.

ACTION: Notice of Proposed Rulemaking.

SUMMARY: The Federal Maritime Commission proposes to amend its regulations governing the publishing, filing and posting of carrier tariffs to eliminate certain outdated or unnecessary regulatory provisions.

DATES: Comments due July 6, 1992. Comments must be received at the Commission by the due date; the date of mailing will not be accepted as the date of filing in this proceeding.

ADDRESSES: Comments are to be submitted to: Joseph C. Polking, Secretary, Federal Maritime Commission, 1100 L Street, NW, Washington, DC 20573, (202) 523-5725.

FOR FURTHER INFORMATION CONTACT: Bryant L. VanBrakle, Director, Bureau of Tariffs, Certification and Licensing, Federal Maritime Commission, 1100 L

Street, NW., Washington, DC 20573, (202) 523-5796.

SUPPLEMENTARY INFORMATION: Rules and regulations governing the publication and filing of tariffs for the waterborne transportation of property and passengers performed by common carriers in the domestic offshore trades, as required by the Shipping Act, 1916, 46 U.S.C. app. 801 *et seq.*, and the Intercoastal Shipping Act, 1933, 46 U.S.C. app. 843 *et seq.*, are set forth in 46 CFR part 550. Similarly, rules and regulations governing the publication and filing of tariffs for the transportation of property performed by common carriers in the U.S./foreign trades, as required by the Shipping Act of 1984, 46 U.S.C. app. 1701 *et seq.*, are set forth in 46 CFR part 580.

A review of parts 550 and 580 disclosed certain provisions which no longer serve any regulatory purpose or whose purpose has expired.

Section 550.1(a)(9), 46 CFR 550.1(a)(9), provides for the exemption from the tariff filing requirements applicable to the domestic offshore trades for transportation by Puget Sound Tug & Barge Company of general cargo in non-self-propelled barges from Seattle, Washington to the vicinity of Kivalina, Alaska, during calendar years 1988 and 1989. This exemption has expired. Similarly, § 580.12(c), 46 CFR 580.12(c), which provides for the continuation of certain time/volume rate contracts entered into prior to June 18, 1984, until July 17, 1985, or the term specified in the contract, whichever occurs first, has expired.

The Federal Maritime Commission ("Commission") also proposes to amend § 550.5(b)(8)(xiv), 46 CFR 550.5(b)(8)(xiv), and delete § 550.8, 46 CFR 550.8.

Section 550.5(b)(8)(xiv) refers to the Automobile Manufacturers' Measurements guide, the publication of which was indefinitely suspended by the Commission on July 15, 1987 (52 FR 26479). Since the Commission suspended its publication, the Commission has not received any complaints or requests to reinstitute publication of the guide. Consequently, the reference to this publication is deleted.

Section 550.8 governs the filing of tariffs applicable to through intermodal transportation in the United States domestic offshore trades. It has been determined that joint rail/water and motor/water rates are subject to the jurisdiction of the Interstate Commerce Commission. See *Puerto Rico Maritime Shipping Authority v. ICC*, 645 F.2d 1102 (D.C. Cir. 1981); *Trailer Marine*

Transportation Co. v. FMC, 602 F.2d 329 (D.C. Cir. 1979).

In view of the above, the Commission proposes the amendment of 46 CFR 550.5(b)(8)(xiv) and the removal of 46 CFR 550.8. If these proposals are adopted, the Commission will ensure that new Part 514, the Automated Tariff Filing and Information system rules, is appropriately conformed.

Although the Commission, as an independent regulatory agency, is not subject to Executive Order 12291, dated February 17, 1981, it nonetheless has reviewed the proposed rule in terms of that Order and determined that the proposed rule is not a "major rule" as defined in Executive Order 12291 because it will not result in:

(1) An annual effect on the economy of \$100 million or more;

(2) A major increase in costs or prices for consumers, individual industries, Federal, State or local government agencies, or geographic regions; or

(3) Significant adverse effects on competition, employment, investment, productivity, innovations, or the ability of United States-based enterprises to compete with foreign-based enterprises in the domestic or export markets.

Pursuant to the Regulatory Flexibility Act, 5 U.S.C. 601 *et seq.*, the Federal Maritime Commission certifies that the proposed rule will not, if adopted, have a significant economic impact on a substantial number of small entities, including small businesses, small organizational units and small government jurisdictions.

This proposed rule does not contain any collection of information requirements as defined by the Paperwork Reduction Act of 1980, as amended. Therefore, OMB review is not required.

List of Subjects

46 CFR Part 550

Maritime carriers, Reporting and recordkeeping requirements.

46 CFR Part 580

Freight, Maritime carriers, Reporting and recordkeeping requirements.

Therefore, pursuant to 5 U.S.C. 553; sections 18, 35 and 43 of the Shipping Act, 1916, 46 U.S.C. app. 817, 833a and 841a; section 2 of the Intercoastal Shipping Act, 1933, 46 U.S.C. app. 844; and sections 8, 10, 11, 12, 13, 17 and 23 of the Shipping Act of 1984, 46 U.S.C. app. 1707, 1709, 1710, 1711, 1712, 1716 and 1722; Title 46, Code of Federal Regulations, is proposed to be amended as follows:

PART 550—[AMENDED]

1. The authority citation for part 550 continues to read as follows:

Authority: 5 U.S.C. 553; 46 U.S.C. app. 812, 814, 815, 817, 820, 833a, 841a, 843, 844, 845, 845a, 845b, and 847.

§ 550. [Amended]

2. Section 550.1(a)(9) is removed.

3. Section 550.5(b)(8)(xiv)(A) introductory text is revised to read as follows:

§ 550.5 Contents of tariffs.

(b) * * *

(8) * * *

(xiv) * * *

(A) Automobiles shall be rated by measure. The cubic measurements for the five most recent model years will be that prescribed by the manufacturer of the particular make and model as shown on pages _____ to _____ herein.

4. Section 550.8 is removed and reserved.

PART 580—[AMENDED]

1. The authority citation for Part 580 continues to read as follows:

Authority: 5 U.S.C. 553; 46 U.S.C. app. 1702-1705, 1707, 1709, 1710-1712, 1714-1716, 1718, and 1722.

§ 580.12 [Removed]

2. Section 580.12(c) is removed.

By the Commission.

Joseph C. Polking,
Secretary.

[FR Doc. 92-13036 Filed 6-3-92; 8:45 am]
BILLING CODE 6730-01-M

FEDERAL COMMUNICATIONS COMMISSION**47 CFR Part 73**

[MM Docket No. 91-259, Rms-7309, 7942, 7943, 7944, 7948]

Radio Broadcasting Services;
Canovanas, Culebra, Las Piedras,
Mayaguez, Quebradillas, San Juan,
Santa Isabel and Vieques, Puerto Rico,
and Christiansted and Fredericksted,
Virgin Islands

AGENCY: Federal Communications Commission.

ACTION: Proposed rule; further notice.

SUMMARY: The Commission requests comments on a counterproposal and

interrelated proposals filed in response to the Notice of Proposed Rule Making in this proceeding. See 56 FR 46763, September 16, 1991. Amor Family Broadcasting Group seeks the allotment of Channel 251A to Santa Isabel, Puerto Rico, as its first local aural transmission service. V.I. Stereo Communications Corp. requests the reallocation of Channel 291B from Christiansted, Virgin Islands, to Vieques, Puerto Rico, the modification of Station WVIS' license accordingly, and the substitution of Channel 254A for unoccupied but applied for Channel 293A at Culebra, Puerto Rico. Luis Hernandez requests the allotment of Channel 253A to Fredericksted, Virgin Islands, as its first local aural transmission service. Carlos J. Colon-Ventura counterproposes the substitution of Channel 252A for Channel 255B at Vieques, the reallocation of Channel to Las Piedras, Puerto Rico, instead of Canovanas, Puerto Rico, and the modification of Station WSAW's license accordingly. These channel allotments require the same channel changes at San Juan, Mayaguez and Quebradillas as set forth in the Notice of Proposed Rule Making, *supra*. See Supplementary Information, *infra*.

DATES: Comments must be filed on or before July 20, 1992, and reply comments on or before August 4, 1992.

ADDRESSES: Federal Communications Commission, Washington DC 20554. In addition to filing comment with the FCC, interested parties should serve the petitioner, or its counsel or consultant, as follows: James L. Oyster, Esq., Route 1, Box 203A, Castleton, Virginia 22716 (Counsel to Arzuaga); Frank R. Jazzo, Esq., Fletcher, Heald & Hildreth, 1225 Connecticut Avenue, NW., suite 400, Washington DC 20036-2679 (Counsel to Colon-Ventura); Jose Manuel Rodriguez, President, Amor Family Broadcasting Group, P.O. Box 1295, Santa Isabel, Puerto Rico 00757 (Petitioner for Santa Isabel); Luis Hernandez, P.O. Box 980, Quebradillas, Puerto Rico 00678 (Petitioner for Fredericksted); John B. Kenkel, Esq., Kenkel & Associates, 1220-19th Street, NW., suite 202, Washington, DC 20036 (Counsel to WKJB); and John P. Bankston, Seq., Hopkins & Sutter, 888-16th Street, NW., Washington, DC 20006 (Counsel to Arso).

FOR FURTHER INFORMATION CONTACT: Leslie K. Shapiro, Mass Media Bureau, (202) 634-6530.

SUPPLEMENTARY INFORMATION: This is a synopsis of the Commission's Further Notice of Proposed Rule Making, MM Docket No. 91-259, adopted May 15,

1992, and released May 29, 1992. The full text of this Commission decision is available for inspection and copying during normal business hours in the FCC Dockets Branch (Room 230), 1919 M Street, NW., Washington, DC. The complete text of this decision may also be purchased from the Commission's copy contractor, Downtown Copy Center, (202) 452-1422, 1714 21st Street, NW., Washington, DC 20036.

Channel 251A can be allotted to Santa Isabel in compliance with the Commission's minimum distance separation requirements with a site restriction of 3.6 kilometers (2.3 miles) east to avoid a short-spacing to proposed Channel 254B at Mayaguez, at coordinates North Latitude 17-58-12 and West Longitude 66-22-09. Channel 291B can be allotted to Vieques without the imposition of a site restriction, at coordinates 18-19-39; 65-18-05. Channel 254A can be allotted to Culebra without the imposition of a site restriction, at coordinates 18-18-18; 65-18-06. Channel 253A can be allotted to Fredericksted, without the imposition of a site restriction, at coordinates 17-42-48; 64-53-00. Channel 252A can be allotted to Las Piedras with a site restriction of 14.6 kilometers (19.1 miles) northeast to avoid short-spacings to Stations WBRQ, Channel 249A, Cidra, Puerto Rico, and to proposed Channel 251A at Santa Isabel, at coordinates 18-16-14; 65-45-33.

Provisions of the Regulatory Flexibility Act of 1980 do not apply to this proceeding.

Members of the public should note that from the time a Notice of Proposed Rule Making is issued until the matter is no longer subject to Commission consideration or court review, all *ex parte* contacts are prohibited in Commission proceedings, such as this one, which involve channel allotments. See 47 CFR 1.1204(b) for rules governing permissible *ex parte* contacts.

For information regarding proper filing procedures for comments, see 47 CFR 1.415 and 1.420.

List of Subjects in 47 CFR Part 73

Radio Broadcasting.

Federal Communications Commission.

Michael, C. Ruger,

Acting Chief, Allocations Branch, Policy and Rules Division, Mass Media Bureau.

[FR Doc. 92-13056 Filed 6-3-92; 8:45 am]

BILLING CODE 6712-01-M

INTERSTATE COMMERCE COMMISSION

49 CFR Part 1321

[Ex Parte No. MC-208]

Nonoperating Motor Carriers—Collection of Undercharges

AGENCY: Interstate Commerce Commission.

ACTION: Proposed rules.

SUMMARY: The Commission is proposing rules, that would apply to certain types of undercharge claims asserted by motor carriers that cease operating (because of bankruptcy, voluntary liquidation or otherwise) and/or their representatives. The proposal is prompted by recent attempts by defunct motor carriers to expand their collection efforts so as to unilaterally and retroactively substitute a higher tariff rate for the tariff rate originally billed for a past shipment, or disavow the contract rates where the shipment had moved as contract carriage, on grounds that the tariff or contract rate originally billed was either inapplicable, invalid, or unlawful. The rules would impose procedures to provide for an initial review by the Commission of the claims of these carriers, prior to rebilling and any attempts to collect amounts in addition to those originally billed, to screen out claims that lack any legitimate basis.

DATES: Comments are due July 6, 1992. Replies are not permitted.

ADDRESSES: Send an original and 10 copies of comments referring to Ex Parte No. MC-208 to: Office of the Secretary, Case Control Branch, Interstate Commerce Commission, Washington, DC 20423.

FOR FURTHER INFORMATION CONTACT: Thomas Dahl (202) 927-5289 or Richard Felder (202) 927-5610 [TDD for hearing impaired: (202) 927-5721].

SUPPLEMENTARY INFORMATION: The Commission is instituting a rulemaking proceeding on its own motion to consider whether to adopt regulations to address the problem of undercharge collections by motor carriers that have ceased operating or by their trustees, agents, or assigns. The Commission's general authority to supervise motor carrier rates and tariff publication vest it with primary jurisdiction to determine in the first instance (subject to appropriate court review) whether a particular rate is unreasonable, unlawful, and/or inapplicable. In addition, the Commission has primary jurisdiction to determine whether a transportation service constitutes contract or common carriage, and whether credit and

collection practices are unreasonable and unlawful.

In the past the Commission has not always insisted upon exercising its oversight authority to the fullest extent by directly supervising every single undercharge claim that a carrier may bring. However, based on recent experience, the Commission preliminarily concludes that it needs to exercise its oversight authority to the fullest extent over the claims of carriers that are no longer operating, since that is where the potential for abuse is the greatest. Therefore, the Commission now proposes procedures to provide for an initial review by the Commission of certain types of claims by these carriers and/or their representatives, prior to rebilling. The full text of the proposed regulations is set forth below.

Additional information is contained in the Commission's decision. To obtain a copy of the full decision, write to, call, or pick up in person from: Office of the Secretary, room 2215, Interstate Commerce Commission, Washington, DC 20423. Telephone: (202) 927-7428. [Assistance for the hearing impaired is available through TDD services (202) 927-5721.]

Environmental and Energy Considerations

The Commission preliminarily concludes that the proposed action will not significantly affect either the quality of the human environment or the conservation of energy resources.

Initial Regulatory Flexibility Analysis

The Commission also preliminarily concludes that the proposed regulations would not have a significant economic impact on a substantial number of small entities.

List of Subjects in 49 CFR part 1321.

Motor carriers, Undercharges.

Decided: May 28, 1992.

By the Commission, Chairman Philbin, Vice Chairman McDonald, Commissioners Simmons, Phillips, and Emmett.

Sidney L. Strickland, Jr.,
Secretary.

For the reasons set forth in the Preamble, the Commission proposes to amend title 49, chapter X, of the Code of Federal Regulations, by adding a new part 1321 as follows:

PART 1321—NONOPERATING MOTOR CARRIERS—COLLECTION OF UNDERCHARGES

Sec.

1321.1 Nonoperating motor carriers—undercharge collection.

1321.2 Disavowal of tariff rates.

1321.3 Disavowal of contract carrier charges.

1321.4 Notice to shipper.

1321.5 Scope of rules.

Authority: 49 U.S.C. 10101, 10102, 10321, 10521, 10701, 10702, 10704, 10741, 10743, 10761, 10762, 10764, 10921, 10923, 11144, 11901, 11903, 11904, 11906; 5 U.S.C. 553.

§ 1321.1 Nonoperating motor carriers—undercharge collection.

Motor carriers that have ceased operation (because of bankruptcy, voluntary liquidation or otherwise), as well as their representatives, estates, assigns, or others who may assert undercharge claims purportedly founded on the regulatory requirements of the Interstate Commerce Act or Commission regulations, are subject to the rules in this part at all stages of the collection process, including the initial phase of rebilling. These regulations extend to pending claims (including claims already pending in court), as well as future claims.

§ 1321.2 Disavowal of tariff rates.

A person subject to this Part seeking to rebill for a past shipment based on the substitution of a different (higher) tariff rate for the tariff rate billed at the time of shipment, whether on lawfulness, reasonableness, or applicability grounds, must obtain prior Commission review and approval for the substitution of the different tariff rates.

§ 1321.3 Disavowal of contract carrier charges.

A person subject to this Part seeking to rebill for a past shipment based on the substitution of a common carrier tariff rate for contract carriage charges originally billed, must obtain prior Commission review and approval for the substitution of a (higher) tariff rate.

§ 1321.4 Notice of shipper.

A person subject to this Part seeking undercharges that are covered by these rules must notify the shipper in writing, simultaneously with its filing with the Commission (or following the effective date of these regulations, for pending claims), to advise that:

(a) The Commission has/or will give a preliminary review to the undercharge claims under § 1321.2 or 1321.3 (as appropriate);

(b) In doing so the Commission will consider any affirmative defenses that the shipper may raise based on the Interstate Commerce Act or Commission regulations; and

(c) The shipper may contact the Commission's Office of Public Assistance or the Bureau of Traffic's

Section of Rates and Informal Cases for further information and assistance.

§1321.5 Scope of rules.

The provisions of this Part do not apply to rebillings that:

(a) Seek to collect the (lowest available) tariff rate where the rate originally billed was not contained in a tariff on file with the Commission; or

(b) Seek to collect the unpaid portion of the originally billed tariff rate or contract charges, together with any interest or late payment charges that are permitted by Commission regulations.

[FR Doc. 92-13093 Filed 6-3-92; 8:45 am]

BILLING CODE 7035-01-M

Notices

Federal Register

Vol. 57, No. 108

Thursday, June 4, 1992

This section of the FEDERAL REGISTER contains documents other than rules or proposed rules that are applicable to the public. Notices of hearings and investigations, committee meetings, agency decisions and rulings, delegations of authority, filing of petitions and applications and agency statements of organization and functions are examples of documents appearing in this section.

DEPARTMENT OF AGRICULTURE

Forms Under Review by Office of Management and Budget

May 29, 1992.

The Department of Agriculture has submitted to OMB for review the following proposals for the collection of information under the provisions of the Paperwork Reduction Act (44 U.S.C. chapter 35) since the last list was published. This list is grouped into new proposals, revisions, extensions, or reinstatements. Each entry contains the following information:

- (1) Agency proposing the information collection;
- (2) Title of the information collection;
- (3) Form number (s), if applicable;
- (4) How often the information is requested;
- (5) Who will be required or asked to report;
- (6) An estimate of the number of responses;
- (7) An estimate of the total number of hours needed to provide the information;
- (8) Name and telephone number of the agency contact person.

Questions about the items in the listing should be directed to the agency person named at the end of each entry. Copies of the proposed forms and supporting documents may be obtained from: Department Clearance Officer, USDA, OIRM, Room 404-W Admin. Bldg., Washington, DC 20250, (202) 690-2118.

Reinstatement

• Farmers Home Administration. 7 CFR 1955-B, Management of Property. On occasion. Individuals or households; State or local governments; Businesses or other for-profit; Small businesses or organizations; Federal agencies or employees; 2,810 responses; 960 hours. Jack Holston (202) 720-9736.

Extension

• Farmers Home Administration. 7 CFR 1980-G, Nonprofit National Corporation Loan and Grant Program. FmHA 1980-60, 61, and 63. On occasion; Quarterly; Recordkeeping. State or local governments; Businesses or other for-profit; Non-profit institutions; 354 responses; 487 hours. Jack Holston (202) 720-9736.

Donald E. Hulcher,
Deputy Departmental Clearance Officer.

[FR Doc. 92-13066 Filed 6-2-92; 8:45 am]

BILLING CODE 3410-01-M

Forest Service

Exemption From Appeal, Far East Salvage and Recovery Project, Boise National Forest, Idaho

AGENCY: Forest Service, USDA.

ACTION: Notice of exemption from appeal.

SUMMARY: This is notification that timber salvage harvest, insect baiting and trapping, and reforestation activities to rehabilitate and recover natural resources from recent insect epidemics on the Far East project area of the Lowman Ranger District on the Boise National Forest are exempt from appeal in accordance with 36 CFR 217.4(a)(11).

DATES: The appeal exemption is effective on publication of this notice in the *Federal Register*. The Far East final environmental impact statement is effective 30 days after publication of the Notice of Availability in the *Federal Register*.

FOR FURTHER INFORMATION CONTACT: Mark Sigrist, Timber Management Assistant, Lowman Ranger District, Boise National Forest, HC 77 Box 3020, Lowman, ID 83637, Telephone: 208-259-3361.

SUPPLEMENTARY INFORMATION: Several years of drought in southwest Idaho have reduced soil moisture and weakened conifer trees. Consequently, douglas-fir bark beetle, mountain pine beetle, and tussock moth insect populations have dramatically increased and reached epidemic levels on the Boise National Forest. It is estimated that more than 400,000 trees larger than 12 inches in diameter have died on the

Forest since 1986 as a result of insect damage.

As part of the effort to rehabilitate and recover natural resources damaged by the insect epidemic, the Lowman Ranger District has developed a proposal to harvest dead and dying timber, bait and trap insects, and reforest damaged acres. The Lowman District has analyzed the Far East area and has identified issues, developed alternatives, and analyzed the effects of implementing timber salvage and other recovery activities, and documented the results of the analysis in an environmental impact statement.

The analysis area for Far East is located ten miles east of Lowman, Idaho. The area consists of 13,000 acres with insect damage and mortality scattered throughout. The Forest will harvest approximately 15 million board feet of dead and dying trees using helicopter logging systems. Cutting areas would average less than five acres in size and would not exceed 25 acres. Cutover areas greater than 20 acres would be replanted, and smaller areas may be replanted depending on accessibility. Natural regeneration would be used to reforest smaller areas. The Forest also proposes to bait and trap insects within the project area to help break up breeding cycles and reduce future insect populations. There is no new road construction proposed for the salvage operations.

Management direction for the Far East area is established in the Boise National Forest Land and Resource Management Plan (Forest Plan). The Forest Plan provides for the removal of salvage timber from lands within the project areas. In addition, the Forest Plan describes standards which must be met when harvesting timber to protect soil, water, wildlife, visual, and other on-site resources. The proposed action for the Far East project is consistent with standards and guidelines, objectives, and direction contained in the Forest Plan.

Far East contains a 2260 acre portion of the Ten Mile/Black Warrior Inventoried Roadless Area. The portion of this roadless area that is within the proposed salvage area has been allocated to commercial timber production by the Forest Plan. Approximately 12 million board feet would be harvested from the roadless area using helicopters. Landings would

be constructed adjacent to existing roads outside the roadless area.

Forest Pest Management specialists and District foresters have analyzed the insect situation and have found no economical or practical means to control the insect epidemic. Although salvage harvesting, bating/trapping, and reforestation will not control the epidemic, these activities will: (1) Help to break up insect breeding cycles, (2) recover valuable timber that would otherwise deteriorate, and (3) reforest those areas that have been left without tree cover as a result of the insect-caused mortality. It is extremely important to remove the dead and dying timber prior to deterioration and subsequent value losses. Through the salvage timber sale, breeding insects can be trapped and removed and Knutson-Vandenburg (K-V) funds can be generated for use to restore forest resources that have been damaged by the insect epidemic.

The Forest Supervisor has determined through preliminary scoping and environmental analysis that there is sufficient justification to expedite this project. The decision will be implemented after publication of this notice in the *Federal Register*, and the final environmental impact statement will be implemented after 30 days from the publication of a Notice of Availability in the *Federal Register*.

If the project is delayed because of an appeal (delays of up to 150 days are possible), it is likely that the salvage harvest could not be implemented during the 1992 normal operating season. This would result in a loss of volume and value of the timber due to deterioration. The total estimated value of the merchantable dead and dying timber is \$1,000,000. Of this, approximately \$250,000 would be returned to counties from 25 percent fund receipts. Delays resulting from appeals could cause the loss of up to half of this value and potentially make the salvage sale unattractive to timber purchasers, which would jeopardize the objectives of the rehabilitation and recovery project.

Pursuant to 36 CFR 217.4(a)(11), it is my decision to exempt the Far East Salvage and Recovery Project, Idaho City Ranger District, Boise National Forest, from appeal. The final environmental impact statement discloses the effects of the proposed action on the environment and addresses issues resulting from the proposal.

Dated: May 29, 1992.

Clair C. Beasley,

Deputy Regional Forester, Intermountain Region, USDA Forest Service.

[FR Doc. 92-13016 Filed 6-3-92; 8:45 am]

BILLING CODE 3410-11-M

Exemption From Appeal, Featherville Salvage Sale, Boise National Forest, ID.

AGENCY: Forest Service, USDA.

ACTION: Notice of exemption from appeal.

SUMMARY: This is notification that timber salvage harvest and reforestation activities to recover and rehabilitate natural resources from recent insect epidemics on the Featherville project area, Mountain Home Ranger District, Boise National Forest, are exempt from appeal in accordance with 36 CFR 217.4(a)(11).

DATES: June 4, 1992.

FOR FURTHER INFORMATION CONTACT: Steve Williams, Timber Management Assistant, Mountain Home Ranger District, Boise National Forest, 2180 American Legion Boulevard, Mountain Home, ID 83647, Telephone: 208-587-7961.

SUPPLEMENTARY INFORMATION: Several years of drought in southwest Idaho have reduced soil moisture and weakened conifer trees. Consequently, Douglas-fir tussock moth, and bark beetle populations have dramatically increased and reached epidemic levels on the Boise National Forest. It is estimated that more than 400,000 trees larger than 12 inches in diameter have died on the Forest as a result of insect damage since 1986.

As part of the effort to recover and rehabilitate natural resources damaged by the insect epidemic, Mountain Home Ranger District personnel have developed a proposal to harvest dead and dying timber, and reforest damage acres. The Forest Service has analyzed the Featherville Salvage Area and has identified issues, developed alternatives, and analyzed the effects of implementing timber salvage and other recovery activities.

The analysis area for the Featherville Environmental Assessment (EA) is located 60 miles northeast of Mountain Home, Idaho. The area includes about 40,000 acres with insect mortality scattered throughout. The Forest will harvest approximately 10 million board feet of dead and dying trees using helicopter logging system. Cutting areas would average less than five acres in size and would not exceed 20 acres.

Cutover areas greater than 10 acres would be replanted, and smaller areas may be replanted depending on accessibility. Natural regeneration would be used to reforest smaller areas.

There is no road construction or reconstruction proposed for the salvage operations. Helicopter landings would be constructed or reconstructed along existing roads.

Management direction for the Featherville area is established in the Boise National Forest Land and Resource Management Plan (Forest Plan). The Forest Plan provides for the removal of salvage timber from lands within the project area. The Forest Plan also describes standards to protect soil, water, wildlife, visual, and other resources, when harvesting timber. The proposed action for the Featherville project is consistent with standards and guidelines, objectives, and direction contained in the Forest Plan.

The Featherville Salvage Area includes a portion of the Rainbow (15,400 acres), and all of the Whiskey Jack (7,700 acres) Inventoried Roadless Areas. Both Roadless Areas within the Featherville Management Area have been allocated to commercial timber production as well as other multiple uses by the Forest Plan. Approximately eight million board feet would be harvested from the Roadless Areas using helicopters. Landings would be constructed adjacent to existing roads outside the roadless areas.

Forest Pest Management Specialists and District Foresters have analyzed the insect situation and have found no economical or practical means to control the insect epidemic. Although salvage harvesting and reforestation will not control the epidemic, these activities will: (1) Recover value timber that would otherwise deteriorate, and (2) reforest those areas that have been left without tree cover as a result of the insect-caused mortality. It is extremely important to remove the dead and dying timber prior to deterioration and subsequent value losses. Through the salvage timber sale, breeding insects can be removed in the logs (bark beetles) and Knutson-Vandenburg (K-V) funds can be generated for use to restore forest resources that have been damaged by the insect epidemic.

The Forest Supervisor has determined through preliminary scoping and environmental analysis that there is sufficient justification to expedite this project. The decision will be implemented after publication of this notice in the *Federal Register*.

If the project is delayed because of an appeal (delays of up to 150 days are

possible), it is likely that the salvage harvest could not be implemented during the 1992 normal operating season. This would result in a loss of volume and value of the timber due to deterioration. The total estimated value of the merchantable dead and dying timber is \$750,000. Of this, approximately \$187,000 would be returned to counties from 25 percent fund receipts. Delays resulting from appeals could cause the loss of up to half of this value and potentially make the salvage sale unattractive to timber purchasers. This would jeopardize the objectives of the recovery and rehabilitation project.

Pursuant to 36 CFR 217.4(a)(11), it is my decision to exempt the Featherville Salvage and Recovery Project, Mountain Home Ranger District, Boise National Forest, from appeal. The environmental assessment discloses the effects of the proposed actions on the environment and will address issues resulting from the proposal.

Dated: May 29, 1992.

Clair C. Beasley,
Deputy Regional Forester, Intermountain
Region, USDA Forest Service.

[FR Doc. 92-13015 Filed 6-3-92; 8:45 am]

BILLING CODE 3410-15-M

Soil Conservation Service

Upper North Bosque River Watershed Erath and Hamilton Counties, TX; Finding of No Significant Impact

AGENCY: Soil Conservation Service,
USDA.

ACTION: Notice of a finding of no
significant impact.

SUMMARY: Pursuant to section 102(2)(C) of the National Environmental Policy Act of 1969; the Council on Environmental Quality Guidelines (40 CFR part 1500); and the Soil Conservation Service Guidelines (7 CFR part 650); the Soil Conservation Service, U.S. Department of Agriculture, gives notice that an environmental impact statement is not being prepared for the Upper North Bosque River Watershed, Erath and Hamilton Counties, Texas.

FOR FURTHER INFORMATION CONTACT:
Harry W. Oneth, State Conservationist,
Soil Conservation Service, 101 South
Main, Temple, Texas 76501-7682,
telephone (817) 774-1214.

SUPPLEMENTARY INFORMATION: The environmental assessment of this federally assisted action indicates that the project will not cause significant local, regional, or national impacts on the environment. As a result of these findings, Harry W. Oneth, State

Conservationist, has determined that the preparation and review of an environmental impact statement are not needed for this project.

The project will improve surface water and ground water quality in and below the watershed by assisting in a program to reduce the pollutant load from dairies by 70 percent. The plan will provide financial and technical assistance to install animal waste management systems and associated land treatment practices on 31 dairy farms. Implementation of the plan will be accomplished through the local soil and water conservation districts. This project will be supplemented by the Agricultural Conservation Program and Great Plains Conservation Program in the watershed. The plan will be applied during a ten-year period.

The Notice of a Finding of No Significant Impact (FONSI) has been forwarded to the Environmental Protection Agency and to various Federal, State, and local agencies and interested parties. A limited number of copies of the FONSI are available to fill single copy requests at the above address. Basic data developed during the environmental assessment are on file and may be reviewed by contacting Harry W. Oneth.

No administrative action on implementation of the proposal will be taken until 30 days after the date of this publication in the Federal Register.

Dated: May 20, 1992.

Harry W. Oneth,
State Conservationist.

[FR Doc. 92-13120 Filed 6-3-92; 8:45 am]

BILLING CODE 3410-16-M

DEPARTMENT OF COMMERCE

International Trade Administration

University of Nebraska-Lincoln, et al.; Consolidated Decision on Applications for Duty-Free Entry of Scientific Instruments

This is a decision consolidated pursuant to section 6(c) of the Educational, Scientific, and Cultural Materials Importation Act of 1966 (Pub. L. 89-651, 80 Stat. 897; 15 CFR part 301). Related records can be viewed between 8:30 a.m. and 5 p.m. in room 4211, U.S. Department of Commerce, 14th and Constitution Avenue, NW., Washington, DC.

Comments: None received. **Decision:** Approved. No instrument of equivalent scientific value to the foreign instruments described below, for such purposes as each is intended to be used,

is being manufactured in the United States.

Docket Number: 92-030. **Applicant:** University of Nebraska-Lincoln, Lincoln, NE 68588-0340. **Instrument:** Electro-magnetic Geophysical Survey Instrument, Model EM16/EM16R. **Manufacturer:** Geonics Ltd., Canada. **Intended Use:** See notice at 57 FR 11936, April 8, 1992. **Reasons:** The foreign instrument provides measurements of the quadphase as well as the inphase secondary field and measures the secondary field as a ratio of the primary field for independent measurements of absolute field strength. **Advice Received From:** The U.S. Geological Survey, May 8, 1992.

Docket Number: 92-026. **Applicant:** Virginia Polytechnic Institute and State University, Blacksburg, VA 24061-0211. **Instrument:** Distillation Unit, Model CH81. **Manufacturer:** Normag, Germany. **Intended Use:** See notice at 57 FR 11936, April 8, 1992. **Reasons:** The foreign instrument provides: (1) Flexibility for a wide range of distillation/separation applications, (2) a 20-plate column and, (3) five different feed points available by a simple turning of valves. **Advice Received From:** The National Institute of Petroleum and Energy Research, May 19, 1992.

Docket Number: 92-027. **Applicant:** U.S. Geological Survey, Sioux Falls, SD 57198. **Instrument:** Color Digital Image Recorder, Model Color Fire 240. **Manufacturer:** Cymbolic Sciences International, Canada. **Intended Use:** See notice at 57 FR 11936, April 8, 1992. **Reasons:** The foreign instrument provides capability for using roll film rawstock of Aerocolor 2445 type film. **Advice Received From:** The National Oceanic and Atmospheric Administration, May 8, 1992.

Docket Number: 92-037. **Applicant:** University of Hawaii, Honolulu, HI 96822. **Instrument:** Electron Microprobe, Model CAMEBAX SX 50. **Manufacturer:** Cameca Instruments Inc., France. **Intended Use:** See notice at 57 FR 14388, April 20, 1992. **Reasons:** The foreign instrument provides an intense electron beam to excite characteristic x-rays of a sample phase down to 1.0µm area. **Advice Received From:** The National Institute of Standards and Technology, October 23, 1991 (comparable case).

The U.S. Geological Survey, National Institute of Petroleum and Energy Research, National Oceanic and Atmospheric Administration, and National Institute of Standards and Technology advise that (1) the capabilities of each of the foreign instruments described above are pertinent to each applicant's intended

purpose and (2) they know of no domestic instrument or apparatus of equivalent scientific value for the intended use of each instrument.

We know of no other instrument or apparatus being manufactured in the United States which is of equivalent scientific value to any of the foreign instruments.

Frank W. Creel,

Director, Statutory Import Programs Staff.

[FR Doc. 92-13132 Filed 6-3-92; 8:45 am]

BILLING CODE 3510-DS-M

Applications For Duty-Free Entry of Scientific Instruments

Pursuant to section 6(c) of the Educational, Scientific and Cultural Materials Importation Act of 1966 (Pub. L. 89-651; 80 Stat. 897; 15 CFR part 301), we invite comments on the question of whether instruments of equivalent scientific value, for the purposes for which the instruments shown below are intended to be used, are being manufactured in the United States.

Comments must comply with Subsections 301.5(a) (3) and (4) of the regulations and be filed within 20 days with the Statutory Import Programs Staff, U.S. Department of Commerce, Washington, DC 20230. Applications may be examined between 8:30 a.m. and 5 p.m. in Room 4211, U.S. Department of Commerce, 14th and Constitution Avenue, NW., Washington, DC.

Docket Number: 91-188R. **Applicant:** Washington State University, Division of Purchasing, French Administration Building, room 220, Pullman, WA 99164-1020. **Instrument:** Rheometer. **Manufacturer:** Physica Messtechnik GmbH U Co., KG, Germany. Original notice of this resubmitted application was published in the *Federal Register* of January 15, 1992.

Docket Number: 92-064. **Applicant:** Northwest Missouri State University, West 7th Street, Maryville, MO 64468. **Instrument:** Stopped-flow Spectrometer, Model SF-1B. **Manufacturer:** Hi-Tech Scientific, United Kingdom. **Intended Use:** The instrument will be used for teaching research techniques to undergraduate students in chemistry that they may become familiar with stopped-flow techniques and chemical kinetics. **Application Received by Commissioner of Customs:** May 6, 1992.

Docket Number: 92-066. **Applicant:** University of Miami, Rosenstiel School of Marine and Atmospheric Science, Division of Marine Biology, 4600 Rickenbacker Causeway, Miami, FL 33149-1098. **Instrument:** (2) Electronic Fish Measuring Boards, Model FMB IV. **Manufacturer:** Limnoterra Atlantic Inc.,

Canada. **Intended Use:** The instrument will be used to make measurements of length, weight and estimation of age in order to determine distributional characteristics of the spanish mackerel stock, *Scomberomorus maculatus*.

Application Received by Commissioner of Customs: May 6, 1992.

Docket Number: 92-067. **Applicant:** University of Vermont, Department of Pharmacology, UVM Medical Research Center, 55A South Park Drive, Colchester, VT 05448-2500. **Instrument:** 3-D Micromanipulator. **Manufacturer:** Narishige, Japan. **Intended Use:** The instrument will be used for studies of single ion channels from cellular membranes using the patch clamp technique. This allows the measurement of ionic flow through single ion channels from which the functional and kinetic properties of the ion channel can be determined. The main objective of these studies is to characterize different types of ion channels. **Application Received by Commissioner of Customs:** May 11, 1992.

Docket Number: 92-068. **Applicant:** Northwestern University Medical School, 303 East Chicago Avenue, Chicago, IL 60611. **Instrument:** Multi electrode Neuronal Recording System. **Manufacturer:** UWE Thomas Recording, Germany. **Intended Use:** The instrument will be used to study the interactions between neurons in the motor cortex and cerebellum, two structures which are critically involved in the control of limb movement in both monkeys and humans. The studies involve training monkeys to perform a particular sequence of limb movements, while recording the activity of the relevant neurons. **Application Received by Commissioner of Customs:** May 13, 1992.

Frank W. Creel,

Director, Statutory Import Programs Staff.

[FR Doc. 92-13131 Filed 6-3-92; 8:45 am]

BILLING CODE 3510-DS-M

National Institute of Standards and Technology

Announcement of Meeting of National Conference on Weights and Measures

AGENCY: National Institute of Standards and Technology, Commerce.

ACTION: Notice of meeting.

SUMMARY: Notice is hereby given that the 77th Annual Meeting of the National Conference on Weights and Measures will be held July 19 through 23, 1992, at the Stouffer Nashville Hotel, Nashville, Tennessee. The meeting is open to the public.

The National Conference on Weights and Measures is an organization of weights and measures enforcement officials of the States, counties, and cities of the United States, and private sector representatives. The interim meeting of the conference, held in January 1992, as well as the annual meeting, bring together enforcement officials, other government officials, and representatives of business, industry, trade associations, and consumer organizations to discuss subjects that relate to the field of weights and measures technology and administration.

Pursuant to section 2(5) of its Organic Act (15 U.S.C. 272(5)), the National Institute of Standards and Technology acts as a sponsor of the National Conference on Weights and Measures in order to promote uniformity among the States in the complex of laws, regulations, methods, and testing equipment that comprises regulatory control by the States of commercial weighing and measuring.

DATE: The meeting will be held July 19-23, 1992.

LOCATION OF MEETING: Stouffer Nashville Hotel, Nashville, Tennessee.

FOR FURTHER INFORMATION CONTACT: Carroll S. Brickenkamp, Executive Secretary, National Conference on Weights and Measures, P.O. Box 4025, Gaithersburg, Maryland 20885. Telephone (301) 975-4005.

Dated: May 28, 1992.

John W. Lyons,

Director.

[FR Doc. 92-12984 Filed 6-3-92; 8:45 am]

BILLING CODE 3510-13-M

National Oceanic and Atmospheric Administration

Mid-Atlantic Fishery Management Council; Public Meetings

AGENCY: National Marine Fisheries Service, NOAA, Commerce.

The Mid-Atlantic Fishery Management Council (Council) and its following Committees will hold meetings at the Radisson Hotel Philadelphia Airport, 500 Stevens Drive, Philadelphia, PA, telephone: (215) 521-5900. The meeting will be held on June 23, 24, and 25, 1992.

The committee meetings to be held on June 23 are: **Bluefish Monitoring Committee**—10 a.m. until 12 p.m. **Coastal Migratory Species Committee**—1:30 p.m. until 2:30 p.m. **Habitat Committee**—1:30 p.m. until 4 p.m. **Large**

Pelagic Committee—2:30 p.m. until 4 p.m.

There will also be a scoping meeting on scup & black sea bass beginning at 7:00 p.m.

The Council will begin its regular meeting on June 24 at 8:00 a.m. and adjourn on June 25 at approximately 1 p.m. There will also be a hearing on the revision to the Summer Flounder Fishery Management Plan Amendment #2 on June 24 at 7:00 p.m.

In addition to hearing committee reports, the Council will be making its recommendations to the Regional Director for bluefish management in 1993; is scheduled to adopt the resubmission of Amendment #2; will hold discussion on artificial reefs and other fishery management matters as deemed necessary. The Council also may go into closed session (not open to the public) to discuss personnel and/or national security matters.

For more information, contact John C. Bryson, Executive Director, Mid-Atlantic Fishery Management Council, room 2115, Federal Building, 300 South New Street, Dover, DE 19901; telephone: (302) 674-2331.

Dated: June 1, 1992.

David S. Crestin,
Deputy Director, Office of Fisheries
Conservation and Management, National
Marine Fisheries Service.

[FR Doc. 92-13128 Filed 6-3-92; 8:45 am]
BILLING CODE 3510-22-M

Pacific Fishery Management Council; Public Meeting

AGENCY: National Marine Fisheries Service, NOAA, Commerce.

The Pacific Fishery Management Council's (Council) Coastal Pelagic Species Advisory Subpanel and Plan Development Team will hold a public meeting on June 30, 1992, beginning at 11 a.m. The meeting will be held at the National Marine Fisheries Service, Southwest Regional office, 501 West Ocean Boulevard, suite 4200, Long Beach, CA.

The purpose of this meeting is to discuss the preliminary anchovy biomass estimate and status of the fishery. There will not be discussions on the draft fishery management plan being developed to manage anchovy, Pacific mackerel, sardines, and jack mackerel.

For more information contact Patricia Wolf from the California Department of Fish and Game at (213) 590-5117 or Larry Jacobson from the National Marine Fisheries Service at (619) 546-7117. For those individuals planning on

attending this meeting, there is no public parking in the building, however, public parking is available immediately behind the building on Magnolia Street at a cost of \$3.00 per day.

Dated: June 1, 1992.

David S. Crestin,
Deputy Director, Office of Fisheries
Conservation and Management, National
Marine Fisheries Service.

[FR Doc. 92-13127 Filed 6-3-92; 8:45 am]

BILLING CODE 3510-22-M

COMMITTEE FOR THE IMPLEMENTATION OF TEXTILE AGREEMENTS

Adjustment and Correction of an Import Limit for Certain Man-Made Fiber Textile Products Produced or Manufactured in Indonesia

June 1, 1992.

AGENCY: Committee for the
Implementation of Textile Agreements
(CITA).

ACTION: Issuing a directive to the
Commissioner of Customs adjusting and
correcting a limit.

EFFECTIVE DATE: June 8, 1992.

FOR FURTHER INFORMATION CONTACT:
Jennifer Tallarico, International Trade
Specialist, Office of Textiles and
Apparel, U.S. Department of Commerce,
(202) 377-4212. For information on the
quota status of this limit, refer to the
Quota Status Reports posted on the
bulletin boards of each Customs port or
call (202) 535-9480. For information on
embargoes and quota re-openings, call
(202) 377-3715.

SUPPLEMENTARY INFORMATION:

Authority: Executive Order 11651 of March 3, 1972, as amended; section 204 of the Agricultural Act of 1956, as amended (7 U.S.C. 1854).

The current limit for Category 641 is being increased for carryforward. The adjusted limit includes a correction to a previous directive.

A description of the textile and apparel categories in terms of HTS numbers is available in the **CORRELATION:** Textile and Apparel Categories with the Harmonized Tariff Schedule of the United States (see **Federal Register** notice 56 FR 60101, published on November 27, 1991). Also see 56 FR 26392, published on June 7, 1991; and 57 FR 20250, published on May 12, 1991.

The letter to the Commissioner of Customs and the actions taken pursuant to it are not designed to implement all of the provisions of the bilateral agreement, but are designed to assist

only in the implementation of certain of its provisions.

Auggie D. Tantillo,
Chairman, Committee for the Implementation
of Textile Agreements.

**Committee for the Implementation of Textile
Agreements**

June 1, 1992.

Commissioner of Customs,
Department of the Treasury, Washington, DC
20229.

Dear Commissioner: This directive amends, but does not cancel, the directive issued to you on June 4, 1991, by the Chairman, Committee for the Implementation of Textile Agreements. That directive concerns imports of certain cotton, wool, man-made fiber, silk blend and other vegetable fiber textiles and textile products, produced or manufactured in Indonesia and exported during the twelve-month period which began on July 1, 1991 and extends through June 30, 1992.

Effective on June 8, 1992, you are directed to increase the current limit for Category 641 to 1,772,310 dozen¹, as provided under the terms of the current bilateral textile agreement between the Governments of the United States and Indonesia.

The Committee for the Implementation of Textile Agreements has determined that this action falls within the foreign affairs exception to the rulemaking provisions of 5 U.S.C. 553(a)(1).

Sincerely,

Auggie D. Tantillo,
Chairman, Committee for the Implementation
of Textile Agreements.

[FR Doc. 92-13130 Filed 6-3-92; 8:45 am]

BILLING CODE 3510-DR-F

DEPARTMENT OF DEFENSE

Corps of Engineers, Department of the Army

Regulatory Guidance Letters Issued by the Corps of Engineers

AGENCY: Army Corps of Engineers, DoD.

ACTION: Notice.

SUMMARY: The purpose of this notice is to provide a copy of the latest Regulatory Guidance Letter (RGL) to all known interested parties. RGL's are used by the Corps of Engineers as a means to transmit guidance on the permit program (33 CFR 320-330) to its division and district engineers.

FOR FURTHER INFORMATION CONTACT:
Mr. Sam Collinson, Regulatory Branch,
Office of the Chief of Engineers at (202)
272-1782.

SUPPLEMENTARY INFORMATION: In
accordance with a notice published by
the Corps of Engineers on January 22,

¹ The limit has not been adjusted to account for any imports exported after June 30, 1991.

1991, (56 FR 2408), we will publish all RGL's upon issuance. Accordingly, RGL No. 92-1, subject: Federal Agencies Roles and Responsibilities, is hereby published.

John P. Elmore, P.E.,

Chief, Operations, Construction and Readiness Division, Directorate of Civil Works.

Regulatory Guidance Letter, RGL 92-1

Date: 13 May 1992, Expires: 31 December 1997.

Subject: Federal Agencies Roles and Responsibilities.

1. Purpose

The purpose of this guidance is to clarify the Army Corps of Engineers leadership and decision-making role as "project manager" for the evaluation of permit applications pursuant to Section 404 of the Clean Water Act (CWA) and Section 10 of the Rivers and Harbors Act. This guidance is also intended to encourage effective and efficient coordination among prospective permittees, the Corps, and the Federal resource agencies (i.e., Environmental Protection Agency (EPA), Fish and Wildlife Service (FWS), and National Marine Fisheries Service (NMFS)). Implementation of this guidance will help to streamline the permit process by minimizing delays and ensuring more timely decisions, while providing a meaningful opportunity for substantive input from all Federal agencies.

2. Background

(a) The Department of the Army Regulatory Program must operate in an efficient manner in order to protect the aquatic environment and provide fair, equitable, and timely decisions to the regulated public. Clear leadership and a predictable decision-making framework will enhance the public acceptance of the program and allow the program to meet the important objective of effectively protecting the Nation's valuable aquatic resources.

(b) On August 9, 1991, the President announced a comprehensive plan for improving the protection of the Nation's wetlands. The plan seeks to balance two important objectives—the protection, restoration, and creation of wetlands and the need for sustained economic growth and development. The plan, which is designed to slow and eventually stop the net loss of wetlands, includes measures that will improve and streamline the current wetlands regulatory system. This Regulatory Guidance Letter is issued in accordance with the President's plan for protecting wetlands.

(c) The intent of this guidance is to express clearly that the Corps is the decision-maker and project manager for the Department of Army's Regulatory Program. The Corps will consider, to the maximum extent possible, all timely, project-related comments from other Federal agencies when making regulatory decisions. Furthermore, the Corps and relevant Federal agencies will maintain and improve as necessary their working relationships.

(d) The Federal resource agencies have reviewed and concurred with this guidance and have agreed to act in accordance with these provisions. While this guidance does not restrict or impair the exercise of legal authorities vested in the Federal resource agencies or states under the CWA or other statutes and regulations (e.g., EPA's authority under section 404(c), section 404(f), and CWA geographic jurisdiction and FWS/NMFS authorities under the Fish and Wildlife Coordination Act and the Endangered Species Act (ESA)), agency comments on Department of the Army permit applications must be consistent with the provisions contained in this regulatory guidance letter.

3. The Corps Project Management/ Decision Making Role

(a) The Corps is solely responsible for making final permit decisions pursuant to section 10 and section 404(a), including final determinations of compliance with the Corps permit regulations, the section 404(b)(1) Guidelines, and Section 7(a)(2) of the ESA. As such, the Corps will act as the project manager for the evaluation of all permit applications. The Corps will advise potential applicants of its role as the project manager and decision-maker. This guidance does not restrict EPA's authority to make determinations of compliance with the Guidelines in carrying out its responsibilities under Sections 309 and 404(c) of the Clean Water Act.

(b) As the project manager, the Corps is responsible for requesting and evaluating information concerning all permit applications. The Corps will obtain and utilize this information in a manner that moves, as rapidly as practical, the regulatory process towards a final permit decision. The Corps will not evaluate applications as a project opponent or advocate—but instead will maintain an objective evaluation, fully considering all relevant factors.

(c) The Corps will fully consider other Federal agencies' project-related comments when determining compliance with the National Environmental Policy Act (NEPA), the

Section 404(b)(1) Guidelines, the ESA, the National Historic Preservation Act, and other relevant statutes, regulations, and policies. The Corps will also fully consider the agencies' views when determining whether to issue the permit, to issue the permit with conditions and/or mitigation, or to deny the permit.

4. The Federal Resources Agencies' Role

(a) It is recognized that the Federal resource agencies have an important role in the Department of the Army Regulatory Program under the CWA, NEPA, ESA, Magnuson Fisheries Conservation and Management Act, and other relevant statutes.

(b) When providing comments, Federal resource agencies will submit to the Corps only substantive, project-related information on the impacts of activities being evaluated by the Corps and appropriate and practicable measures to mitigate adverse impacts. The comments will be submitted within the time frames established in interagency agreements and regulations. Federal resource agencies will limit their comments to their respective areas of expertise and authority to avoid duplication with the Corps and other agencies and to provide the Corps with a sound basis for making permit decisions. The Federal resource agencies should not submit comments that attempt to interpret the Corps regulations or for the purposes of section 404(a) make determinations concerning compliance with the Section 404(b)(1) Guidelines. Pursuant to its authority under Section 404(b)(1) of the CWA, the EPA may provide comments to the Corps identifying its views regarding compliance with the Guidelines. While the Corps will fully consider and utilize agency comments, the final decision regarding the permit application, including a determination of compliance with the Guidelines, rests solely with the Corps.

5. Pre-Application Consultation

(a) To provide potential applicants with the maximum degree of relevant information at an early phase of project planning, the Corps will increase its efforts to encourage pre-application consultations in accordance with regulations at 33 CFR 325.1(b). Furthermore, while encouraging pre-application consultation, the Corps will emphasize the need for early consultation concerning mitigation requirements, if impacts to aquatic resources may occur. The Corps is responsible for initiating, coordinating, and conducting pre-application consultations and other discussions and

meetings with applicants regarding Department of the Army permits. This may not apply in instances where the consultation is associated with the review of a separate permit or license required from another Federal agency (e.g., the Federal Energy Regulatory Commission or the Nuclear Regulatory Commission) or in situations where resource agencies perform work for others outside the context of a specific Department of the Army permit application (e.g., the Conservation Reserve Program and technical assistance to applicants of Federal grants).

(b) For those pre-application consultations involving activities that may result in impacts to aquatic resources, the Corps will provide EPA, FWS, NMFS (as appropriate), and other appropriate Federal and State agencies, a reasonable opportunity to participate in the pre-application process. The invited agencies will participate to the maximum extent possible in the pre-application consultation, since this is generally the best time to consider alternatives for avoiding or reducing adverse impacts. To the extent practical, the Corps and the Federal resource agencies will develop local procedures (e.g., teleconferencing) to promote reasonable and effective pre-application consultations within the logistical constraints of all affected parties.

6. Applications for Individual Permits

(a) The Corps is responsible for determining the need for, and the coordination of, interagency meetings, requests for information, and other interactions between permit applicants and the Federal Government. In this regard, Federal resource agencies will contact the Corps to discuss and coordinate any additional need for information from the applicant. The Corps will cooperate with the Federal resource agencies to ensure, to the extent practical, that information necessary for the agencies to carry out their responsibilities is obtained. If it is determined by the Corps that an applicant meeting is necessary for the exchange of information with a Federal resource agency and the Corps chooses not to participate in such a meeting, the Federal resource agency will apprise the Corps, generally in writing, of that agency's discussions with the applicant. Notwithstanding such meetings, the Corps is solely responsible for permit requirements, including mitigation and other conditions—the Federal resource agencies must not represent their views as regulatory requirements. In circumstances where the Corps meets with the applicant and develop

information that will affect the permit decision, the Corps will apprise the Federal resource agencies of such information.

(b) Consistent with 33 CFR 325, the Corps will ensure that public notices contain sufficient information to facilitate the timely submittal of project-specific comments from the Federal resource agencies. The resource agencies comments will provide specific information and/or data related to the proposed project site. The Corps will fully consider comments regarding the site from a watershed or landscape scale, including an evaluation of potential cumulative and secondary impacts.

(c) The Corps must consider cumulative impacts in reaching permit decisions. In addition to the Corps own expertise and experience, the Corps will fully consider comments from the Federal resource agencies, which can provide valuable information on cumulative impacts. Interested Federal agencies are encouraged to provide periodically to the Corps generic comments and assessments of impacts (outside the context of a specific permit application) on issues within the agencies' area of expertise.

7. General Permits

(a) The Corps is responsible for proposing potential general permits, assessing impacts of and comments on proposed general permits, and deciding whether to issue general permits. The Corps will consider proposals for general permits from other sources, including the Federal resource agencies, although the final decision regarding the need to propose a general permit rests with the Corps. Other interested Federal agencies should provide comments to the Corps on proposed general permits. These Federal agency comments will be submitted consistent with established agreements and regulations and will focus on the Federal agencies' area(s) of expertise. The Corps will fully consider such agencies' comments in deciding whether to issue general permits, including programmatic general permits.

(b) The Corps is responsible for initiating and conducting meetings that may be necessary in developing and evaluating potential general permits. Any discussions with a State or local Government regarding proposed programmatic general permits will be coordinated through and conducted by the Corps. Prior to issuing a programmatic general permit, the Corps will ensure that the State or local program, by itself or with appropriate conditions, will protect the aquatic environment, including wetlands, to the

level required by the section 404 program.

8. This guidance expires 31 December 1997 unless sooner revised or rescinded.

For the Commander:

Arthur E. Williams,
Major General, USA, Director of Civil Works,
[FR Doc. 92-13118 Filed 6-3-92; 8:45 am]
BILLING CODE 3710-08-M

DEFENSE NUCLEAR FACILITIES SAFETY BOARD

[Recommendation 92-2]

DOE's Facility Representative Program at Defense Nuclear Facilities

AGENCY: Defense Nuclear Facilities
Safety Board.

ACTION: Notice; recommendation.

SUMMARY: The Defense Nuclear Facilities Safety Board has made a recommendation to the Secretary of Energy pursuant to 42 U.S.C. 2286a concerning DOE's facility representative program at defense nuclear facilities. The Board requests public comments on this recommendation.

DATES: Comments, data, views, or arguments concerning this recommendation are due on or before July 6, 1992.

ADDRESSES: Send comments, data, views, or arguments concerning this recommendation to: Defense Nuclear Facilities Safety Board, 625 Indiana Avenue NW., suite 700, Washington, DC 20004.

FOR FURTHER INFORMATION CONTACT: Kenneth M. Pusateri or Carole J. Council, at the address above or telephone (202) 208-6400.

Dated: May 29, 1992.

John T. Conway,
Chairman.

DOE's Facility Representative Program at Defense Nuclear Facilities

Dated: May 28, 1992.

Department of Energy (DOE) Order 5000.3A, *Occurrence Reporting and Processing of Information*, establishes a policy "to assure that both DOE and DOE contractor line management, including the Office of the Secretary, [be] kept fully and currently informed of all events which could affect the health and safety of the public." As a central feature of the measures used to implement this policy, the order defines the position "DOE Facility Representative" as follows:

"DOE Facility Representative. For each major facility or group of lesser facilities, an

individual * * * assigned responsibility by the Head of the Field Organization for monitoring the performance of the facility and its operations. This individual shall be the *primary point of contact* with the contractor and will be responsible to the appropriate Program Secretarial Officer (PSO) and Head of Field Organization * * * [emphasis added]

In addition, DOE Order 5480.19, *Conduct of Operations Requirements for DOE Facilities*, directs that "operations at DOE facilities be * * * conducted in a manner to assure an acceptable level of safety," and specifies that DOE Facility Representatives be "assigned responsibility [to] oversee the day-to-day conduct of operations * * * in accordance with * * * direction received from the Program Manager." Secretary of Energy Notice SEN-6E-92, Departmental Organization and Management Arrangements, extends this chain of responsibility, holding Program Managers accountable to Program Secretarial Officers (PSOs), who in turn are "accountable to [the Secretary] for their respective programs, including safety of the workers and the public * * *"

Recognizing the importance of these positions with regard to assuring adequate protection of the public health and safety at DOE defense nuclear facilities, the Board reviewed existing department-wide guidance on the selection, training and responsibilities of DOE Facility Representatives. DOE Order 5000.3A and DOE Order 5480.19 (both cited above), provide only limited details concerning DOE Facilities Representative duties and responsibilities; moreover, there are no orders that prescribe any guidance for selection and training of DOE Facility Representatives, nor any effective guidance for establishing the duties and responsibilities associated with these positions. (See Appendix A)

Having made numerous reviews throughout the DOE defense nuclear facilities complex, the Board notes that the DOE managers for several facilities in the defense nuclear complex have begun to establish formal Facility Representative programs. However, these programs are operating without centralized direction. Generally, this is resulting in widely differing qualifications, duties, and responsibilities for DOE Facility Representatives from facility to facility, even at the same site. For example, DOE Facility Representatives encountered by the Board have ranged from personnel holding doctoral degrees to summer interns (college students).

This situation could result in failure by DOE to achieve the level of technical

vigilance necessary to assure the safe operation of the department's defense nuclear facilities. The Board believes that the performance of the interrelated safety, technical, and management functions by DOE Facility Representatives would be enhanced if a formal qualification program for these positions, commensurate with their importance, was promulgated at the department level and implemented throughout the defense nuclear facilities complex.

Therefore, the Board recommends that for defense nuclear facilities:

1. The Secretary of the Department of Energy expeditiously carry out a comprehensive analysis of the existing DOE Facility Representative programs.

a. The analysis should be conducted under the direction of a senior individual who has demonstrated high technical and managerial ability and has demonstrated an understanding of the use of facility representatives.

b. The analysis should emphasize the identification of those aspects of the existing programs that either support or impede the achievement of DOE objectives for assuring the protection of public health and safety. Consideration should be given to evaluating:

(1) Qualification requirements and recruitment practices employed in selecting prospective DOE Facility Representatives;

(2) General and facility-specific training and examination requirements and practices necessary to prepare prospective DOE Facility Representatives for field assignments, and to maintain their proficiency;

(3) DOE Facility Representative duties and responsibilities;

(4) Existing supervision and management of the Facility Representative position, now provided by several individuals in some facilities, especially inquiring whether there are clear lines of responsibilities with both the contractor and DOE line management;

(5) Criteria and practices for assigning DOE Facility Representatives to each defense nuclear facility; and

(6) DOE personnel practices and procedures that provide incentives and impediments to making the position of DOE Facility Representative attractive and career-enhancing. At a minimum, restraints imposed by the practice of measuring responsibility predominantly in terms of numbers of individuals supervised should be addressed.

c. The analysis should identify practices employed in successful Facility Representative programs outside of the defense nuclear facilities

complex that are appropriate for the DOE Facility Representative Program.

d. At the conclusion of the analysis, an estimate should be prepared of the personnel and management resources that would be required to establish and maintain an effective DOE Facility Representative Program, and which reflects the results of the analysis.

2. Utilizing the results of the comprehensive analysis, the Secretary of the Department of Energy establish a formal program to select, train, and assign DOE Facility Representatives for the defense nuclear facilities.

a. In establishing this program, DOE should be prepared to modify personnel practices and programs as necessary to establish a beneficial and effective DOE Facility Representative Program.

b. This program should give consideration to:

(1) Delineating DOE Facility Representative selection requirements, including specified standards of educational achievement, professional experience, technical aptitude, and forcefulness;

(2) Establishing DOE Facility Representative training requirements, including a formal centralized core training program, a formal site- and facility(s)-specific training program, and a continuing education and improvement program, each including periodic objective examinations;

(3) Defining DOE Facility Representatives duties and responsibilities, both generically and with regard to each facility in every mode of operation including transition states such as between PSO's; and

(4) Establishing formal requirements to specify those activities or facilities requiring the assignment of DOE Facility Representatives.

John T. Conway,
Chairman.

Appendix A—Review of DOE Facility/Site Representative Position Descriptions

The DNFSB staff has reviewed several current or proposed position descriptions, defining the duties and responsibilities of DOE Facility/Site Representatives at Savannah River, Richland, Idaho National Engineering Laboratory (INEL), Rocky Flats, and the Waste Isolation Pilot Plant (WIPP). Based on these position descriptions, there appears to be a wide disparity in the duties and qualifications for DOE Facility/Site Representatives from facility to facility. The lack of any effective guidance in establishing the duties and responsibilities associated with these positions is supported by the following observations.

The position description for the Facility Representative, WIPP Project Office, (General Engineer GM-801-13) most closely tracks the definition of a "DOE Facility Representative" as defined in DOE Order 5000.3A. The position description properly summarizes the major duties of the facility representative as follows:

"Conducts daily on-site evaluation of contractor operations with emphasis on personnel health and safety, nuclear safety, environmental protection, facility modifications and maintenance, and formality of operations. Assures safe operations at the facility at all times. This is accomplished by frequent walk-through inspections of all facility spaces, observation of facility activities, and continuous interface with contractor personnel at all levels. Deficiencies or concerns are resolved directly with the contractor Facility Manager (with timely appropriate notification to DOE management of the actions taken) or, as necessary, are elevated through DOE line management up to the Operations Office Manager and the Headquarters Program Manager.

"Serves as the primary conduit of information concerning facility operations for DOE management. Maintains awareness of all activities, ongoing and planned, at the facility through discussions with personnel at all levels, through participations in meetings on daily operations and problem resolution, as well as short and long range planning, and through problem identification and resolution resulting from interfacing with personnel at all levels on walk-through inspections and observation of operations. Is responsible for assuring that inspections, observations, and discussions are sufficiently frequent and timely to ensure current knowledge of operations at all times.

"Is normally the first point of contact for DOE in all event notifications and is available to respond to the facility around-the-clock. Serves as the primary DOE expert regarding operational activities and problem identification and resolution."

In contrast, the position description for the Site Representative, Chemical Processing Plant Branch, INEL, includes the following definition of duties:

"Performs surveillance of the facilities to assure that work is being done in accordance with applicable safety standards and specifications, and approved operating and work control procedures. Facility shutdown authority rests with the Assistant Manager for Nuclear Programs. The Site Representative may exercise this authority, after contacting the AM/NP, when in his opinion, operations may result in undue risk to health, safety, or the environment. If time permits, such action will be coordinated with the MPD Director, AM/ES&H, and ID manager. In cases other than imminent danger, the Site Representative will first bring the matter to the attention of facility management. If resolution is not reached, the Site Representative will go through normal DOE-ID line management for directing any change in operations."

The level of knowledge required of individuals assigned to these positions varies widely among the position descriptions

reviewed. All of the position descriptions suffer from a lack of specificity as to how an applicant or an incumbent in these positions will be required to demonstrate his or her proficiency in meeting any of the "Knowledge Requirements" stated in the position description. In fact, no level of educational achievement is cited in any of the position descriptions. The Facility Representative position description for the WIPP Project Office does cite a Professional Engineer license as being highly desirable, but not required. This position description also establishes several performance criteria, including:

"The ability to complete training on safety and environmental regulatory issues, and to apply general and site-specific training toward the demonstration of detailed knowledge of safety-related systems design basis, functions, and operational characteristics."

The position descriptions reviewed are not consistent in the assignment of responsibilities and compensation incentives. It is not readily discernable as to how certain DOE Facility/Site Representatives are given General Schedule classifications (e.g. GS-13) whereas selected DOE Facility/Site Representatives are included in the DOE Performance Management Recognition System. This latter system, based on the concept of pay for performance, is used for individuals assigned to supervisory or policy influencing positions. A convincing argument can be made that a DOE Facility/Site Representative influences the operational policies and procedures for assigned facilities and, therefore, should be assigned to this pay for performance incentive system.

Appendix B—Transmittal Letter to the Secretary of Energy

DEFENSE NUCLEAR FACILITIES SAFETY BOARD

625 Indiana Avenue, NW, Suite 700,
Washington, D.C. 20004, (202) 208-6400 Δ FTS
268-6400

John T. Conway, Chairman, A.J. Eggenberger,
Vice Chairman, John W. Crawford, Jr.,
Herbert John Cecil Kouts
May 28, 1992.

The Honorable James D. Watkins,
Secretary of Energy,
Washington, DC 20585

Dear Mr. Secretary: On May 28, 1992, the Defense Nuclear Facilities Safety Board, in accordance with 42 U.S.C. 2286a(5), unanimously approved Recommendation 92-2 which is enclosed for your consideration. Recommendation 92-2 deals with DOE's facility representative program at defense nuclear facilities.

42 U.S.C. 2286d(a) requires the Board, after receipt by you, to promptly make this recommendation available to the public in the Department of Energy's regional public reading rooms. The Board believes the recommendation contains no information which is classified or otherwise restricted. To the extent this recommendation does not include information restricted by DOE under the Atomic Energy Act of 1954, 42 U.S.C. 2161-68, as amended, please arrange to have this recommendation promptly placed on file in your regional public reading rooms.

The Board will publish this recommendation in the Federal Register.
Sincerely,

John R. Conway,
Chairman.

Enclosure

[FR Doc. 92-12998 Filed 6-3-92; 8:45 am]

BILLING CODE 6820-KD-M

[Recommendation 92-3]

Operational Readiness Reviews for the HB-Line at the Savannah River Site, Aiken, SC

AGENCY: Defense Nuclear Facilities Safety Board.

ACTION: Notice recommendation.

SUMMARY: The Defense Nuclear Facilities Safety Board has made a recommendation to the Secretary of Energy pursuant to 42 U.S.C. 2286a concerning operational readiness reviews for the HB-Line at the Savannah River Site, Aiken, South Carolina. The Board requests public comments on this recommendation.

DATES: Comments, data, views, or arguments concerning this recommendation are due on or before July 6, 1992.

ADDRESSES: Send comments, data, views, or arguments concerning this recommendation to: Defense Nuclear Facilities Safety Board, 625 Indiana Avenue NW., suite 700, Washington, DC 20004.

FOR FURTHER INFORMATION CONTACT: Kenneth M. Pusateri or Carole J. Council, at the address above or telephone (202) 208-6400.

Dated June 1, 1992.

John T. Conway,
Chairman.

[Recommendation 92-3]

Operational Readiness Reviews for the HB-Line at the Savannah River Site, Aiken, South Carolina

Dated: May 29, 1992.

As indicated in our recent Recommendation 92-1, the Board is continuing its oversight and investigation of health and safety issues related to the proposed resumption of plutonium processing in the HB-Line at the Savannah River Site, South Carolina. Our review of Department of Energy (DOE) and contractor documents, as well as other information obtained during the investigation to date, leads the Board to conclude that the Operational Readiness Review (ORR) of the HB-Line conducted by Westinghouse Savannah River Company (WSRC)

during the summer of 1991, and DOE's subsequent review called an "ORE", were premature, limited in scope, and inadequate. Moreover, some of the conclusions reached seem suspect. The Board was particularly concerned that some safety issues requiring resolution prior to resumption of operations (Category 1) were reclassified as post-resumption issues (Category 2), without the concurrence of certain DOE team members, raising a question regarding the supportability of the findings. The ORRs did not ensure adequate resolution and closure of safety and health issues associated with the HB-Line, which had not been operated since 1987. When attempts were made to resume operations in the HB-Line during the summer of 1991, following the ORRs, a series of radiological exposures to workers and other safety incidents occurred, causing operations to be suspended. In October of 1991, the HB-Line resumed operations until March of 1992, when operations were again suspended due to an unreviewed safety question. The Office of Nuclear Safety's review, as well as other assessments of HB-Line, identified safety issues which still have not been resolved.

The Department has placed a priority upon safety resuming HB-Line operations to meet commitments made to NASA. While recognizing that the HB-Line may not pose an undue risk to the off-site public, the Board remains concerned with protection of on-site personnel, since an adequate assessment of operational readiness has not been conducted, nor has an adequate assessment of an accidental ground level release been performed.

The Board has determined that the conduct of adequate and thorough ORRs by WSRC and DOE are essential for identifying and resolving remaining health and safety issues affecting workers, and at the same time promptly achieving readiness for restart.

Therefore, the Board recommends that, prior to resuming operations in the HB-Line:

1. DOE direct WSRC to reopen its ORR, and that WSRC and DOE conduct adequate ORRs in accordance with previous Board recommendations and DOE implementation plans for ORRs at other facilities.

2. Comprehensive criteria documents be established for judging and measuring readiness to restart. The criteria documents should include the bases for judging which safety issues must be resolved prior to resumption, and which issues may be deferred for resolution subsequent to restart.

3. WSRC issue a Readiness to Proceed Memorandum requesting DOE approval for resumption of operations after WSRC has completed its ORR and has determined that safety issues appropriate for closure prior to resumption have been adequately resolved.

4. DOE provide whatever assistance it deems appropriate to WSRC during the contractor's conduct of its ORR, recognizing that such assistance is separate and distinct from DOE's subsequent and independent execution of its own ORR.

5. A DOE ORR team, including a Senior Advisory Group, conduct an independent and comprehensive ORR for HB-Line after (a) WSRC has conducted an adequate ORR and issued a Readiness to Proceed Memorandum requesting DOE approval for resumption of approval of resumption of operations, and (b) DOE has sufficient reason to believe that significant deficiencies affecting the resumption and safe operation of HB-Line have been corrected by the contractor.

6. The DOE ORR team consist of experienced individuals whose backgrounds collectively include all important facets of the operations involved; that the majority of the team members be independent of HB-Line direct line management responsibilities to ensure an independent and unbiased assessment.

7. In preparing for the Operational Readiness Review for the HB-Line, DOE and WSRC should reexamine the HB-Line Safety Analysis Report (SAR) to ensure that: (a) The accident analyses adequately consider all credible scenarios; (b) all appropriate engineered safety systems which are necessary to prevent accidents or mitigate the on-site and off-site consequences of those accidents are identified; and (c) the information obtained from the updated Fire Hazards Analysis is consistent with the accident analyses.

8. WSRC and DOE should complete their assessment of compliance with DOE safety orders at HB-Line, and finish their review, approval, and implementation of any compensatory measures that are necessary and appropriate to achieve the objectives of order compliance and safe resumption of operations at HB-Line.

John T. Conway,
Chairman.

Appendix—Transmittal Letter to the Secretary of Energy

DEFENSE NUCLEAR FACILITIES SAFETY BOARD

625 Indiana Avenue, NW, Suite 700,
Washington, D.C. 20004, (202) 208-6400
• FTS 268-6400

John T. Conway, Chairman, A.J. Eggenberger,
Vice Chairman, John W. Crawford, Jr.,
Herbert John Cecil Kouts

May 29, 1992

The Honorable James D. Watkins,
Secretary of Energy, Washington, DC 20585

Dear Mr. Secretary: In accordance with 42 U.S.C. 2286a(2) the Board has conducted an investigation of DOE and contractor activities at the HB-Line at the Savannah River Site. Pursuant to that investigation which is drawing to a close, the Board sent to you Recommendation 92-1 by letter dated May 21, 1992.

In furtherance of that recommendation, the Defense Nuclear Facilities Safety Board, in accordance with 42 U.S.C. 2286a(5), unanimously approved Recommendation 92-3 which is enclosed for your consideration. Recommendation 92-3 deals with operational readiness reviews for the HB-Line at the Savannah River Site, Aiken, South Carolina.

42 U.S.C. 2286d(a) requires the Board, after receipt by you, to promptly make this recommendation available to the public in the Department of Energy's regional public reading rooms. The Board believes the recommendation contains no information which is classified or otherwise restricted. To the extent this recommendation does not include information restricted by DOE under the Atomic Energy Act of 1954, 42 U.S.C. 2161-68, as amended, please arrange to have this recommendation promptly placed on file in your regional public reading rooms.

The Board will publish this recommendation in the *Federal Register*.

Sincerely,

John T. Conway,
Chairman.

Enclosure

[FR Doc. 92-13061 Filed 6-3-92; 8:45 am]

BILLING CODE 6620-KD-M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Project No. 2179-010 California]

Merced Irrigation District; Availability of Environmental Assessment

May 29, 1992.

In accordance with the National Environmental Policy Act of 1969 and the Federal Energy Regulatory Commission's regulations, 18 CFR Part 380 (Order No. 486, 52 FR 47910), the

Office of Hydropower Licensing (OHL) has reviewed the application for addition of a water delivery system pursuant to article 45 of the license for the New Exchequer Hydroelectric Project. The project is located on the Merced River in Mariposa and Merced Counties, California.

The staff of OHL's Division of Project Compliance and Administration has prepared an Environmental Assessment (EA) for the proposed action. In the EA, staff concludes that approval of a water delivery system would not constitute a major federal action significantly affecting the quality of the human environment.

Copies of the EA are available for review in the Reference and Information Center, room 3308, of the Commission's Offices at 941 North Capitol Street NE., Washington, DC 20426.

Lois D. Cashell,
Secretary.

[FR Doc. 92-13004 Filed 6-3-92; 8:45 am]

BILLING CODE 6717-01-M

[Docket No. TM92-7-22-000]

CNG Transmission Corp.; Proposed Changes in FERC Gas Tariff

May 29, 1992.

Take notice that CNG Transmission Corporation ("CNG"), on May 26, 1992, filed the following tariff sheets for inclusion in its FERC Gas Tariff, First Revised Volume No. 1:

Sixth Revised Sheet No. 45
Seventh Revised Sheet No. 45
Fourth Revised Sheet No. 50

CNG states that the purpose of this filing is to recover revised PSP charges allocated to it by Transcontinental Gas Pipe Line Corporation ("Transco") in Docket No. TM92-10-29-000; Year 2 LPSP charges allocated to CNG by Transco in Docket No. TM92-12-29-000; and take-or-pay costs allocated to CNG by Texas Gas Transmission Corporation in Docket Nos. RP91-61-000, *et al.*

CNG requests effective dates for these proposed tariff sheets of May 27, 1992; June 26, 1992; and August 1, 1991; respectively.

CNG states that copies of this filing were served upon CNG's customers as well as interested state commissions.

Any person desiring to be heard or to protest said filing should file a protest or motion to intervene with the Federal Energy Regulatory Commission, 825 North Capitol Street, NE., Washington, DC 20426, in accordance with Rules 214 and 211 of the Commission's Rules of

Practice and Procedure, 18 CFR 385.214 and 385.211. All motions or protests should be filed on or before June 5, 1992. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a motion to intervene. Copies of this filing are on file with the Commission and are available for public inspection.

Lois D. Cashell,
Secretary.

[FR Doc. 92-13003 Filed 6-3-92; 8:45 am]

BILLING CODE 6717-01-M

[Docket No. TQ92-5-23-000]

Eastern Shore Natural Gas Co.; Proposed Changes in FERC Gas Tariff

May 29, 1992.

Take notice that Eastern Shore Natural Gas Company (ESNG) tendered for filing on May 27, 1992 certain revised tariff sheets included in Appendix A attached to the filing. Such sheets are proposed to be effective June 1, 1992.

ESNG states that the sales rates set forth in the above referenced tariff sheets reflect an increase of \$0.3012 per dt in the commodity rates and an increase of \$0.3772 in the demand rate. The increased gas cost in the instant filing results from:

- (1) Adjusting ESNG's rates to reflect the impact of higher prices being paid to producers/suppliers under ESNG's market responsive gas supply contracts; and
- (2) Updating ESNG's pipeline supplier demand rates.

ESNG states that copies of the filing have been served upon its jurisdictional customers and interested State Commissions.

Any person desiring to be heard or to protest said filing should file a motion to intervene or protest with the Federal Energy Regulatory Commission, 825 North Capitol Street, NE., of the Commission's Rules of Practice and Procedure (18 CFR 385.211 and 385.214). All such motions or protests should be filed on or before June 5, 1992. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a motion to intervene. Copies of this filing are on file with the

Commission and are available for public inspection.

Lois D. Cashell,
Secretary.

[FR Doc. 92-13002 Filed 6-3-92; 8:45 am]

BILLING CODE 6717-01-M

[Docket No. RP92-133-000 (Phase I)]

Gas Research Institute; Second Amendment to the Modified Funding Mechanism

May 28, 1992.

Take notice that on May 26, 1992, the Gas Research Institute (GRI) proposed to amend, for a second time, the modified funding mechanism it had proposed on March 20, 1992 in this proceeding. GRI proposes the following mechanism to fund its research and development program for the remainder of 1992 and for 1993:

1. Collection of the GRI funding unit of 1.47 cents per Dth (*i.e.*, 1.51 cents per Mcf) in conjunction with all nondiscounted commodity charges and one-part rates for transportation services, including those associated with bundled sales transactions, would continue to be accomplished as it is under the existing mechanism, *i.e.*, by applying a volumetric surcharge to the member interstate pipeline transportation services, including those associated with bundled sales. As always, the surcharge will be collected only once on each unit of gas.

2. Funding necessary to make up the GRI estimated revenue shortfall of approximately \$43 million resulting from exempting discounted transactions from GRI funding, would be collected through a uniform demand or reservation surcharge of 8 cents per Dth per month. GRI intends that this surcharge would remain in effect, without change, for the remainder of 1992 and for 1993.

3. An interstate pipeline member's total annual GRI funding responsibility based on transactions involving discounted demand or reservation charges would be limited to 10 percent of its total 1991 GRI contributions.

Comments on the amended funding mechanism and motions to intervene should be filed by June 5, 1992 with the Federal Energy Regulatory Commission, 825 North Capitol Street, NE., Washington, DC 20426. All comments will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make the persons commenting parties to this

proceeding. Accordingly, any person not already a party who wishes to become a party must also file a motion to intervene in accordance with the Commission's rules and regulations. Copies of this filing are on file with the Commission and are available for public inspection.

Lois D. Cashell,

Secretary.

[FR Doc. 92-13000 Filed 6-3-92; 8:45 am]

BILLING CODE 6717-01-M

[Docket No. TQ92-5-18-000]

**Texas Gas Transmission Corp.;
Proposed Changes in FERC Gas Tariff**

May 29, 1992.

Take notice that Texas Gas Transmission Corporation (Texas Gas), on May 27, 1992, tendered for filing the following revised tariff sheets to its FERC Gas Tariff, Original Volume No. 1:

- Fifty-sixth Revised Sheet No. 10
- Fifth-sixth Revised Sheet No. 10A
- Thirty-seventh Revised Sheet No. 11
- Twenty-seventh Revised Sheet No. 11A
- Twenty-seventh Revised Sheet No. 11B

Texas Gas states that these tariff sheets reflect changes in purchased gas costs pursuant to an Out-of-Cycle PGA Rate Adjustment and are proposed to be effective June 1, 1992. Texas Gas further states that the proposed tariff sheets reflect a commodity rate increase of \$.1199 per MMBtu in purchased gas costs from those reflected in the rates set forth in the Out-of-Cycle PGA filed April 29, 1992 (Docket No. TQ92-4-18). No changes are proposed for the demand or SGN Standby rates.

Texas Gas states that copies of the filing have been served upon Texas Gas's jurisdictional customers and interested state commissions.

Any person desiring to be heard or to protest said filing should file a motion to intervene or protest with the Federal Energy Regulatory Commission, 825 North Capitol Street, NE., Washington, DC 20426, in accordance with §§ 385.214 and 385.211 of the Commission's Rules and Regulations. All such protests or motions should be filed on or before June 5, 1992. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a motion to intervene. Copies of this filing are on file with the Commission and are available for public inspection in the Public Reference Room.

Lois D. Cashell,

Secretary.

[FR Doc. 92-13001 Filed 6-3-92; 8:45 am]

BILLING CODE 6717-01-M

Office of Fossil Energy

[FE Docket No. 92-29-NG]

**Williams Gas Marketing Co.; Order
Granting Blanket Authorization To
Import Natural Gas From Canada**

AGENCY: Office of Fossil Energy, DOE.

ACTION: Notice of order.

SUMMARY: The Office of Fossil Energy of the Department of Energy gives notice that it has issued an order granting Williams Gas Marketing Company blanket authorization to import up to 200 Bcf of natural gas from Canada over a two-year term, beginning on the date of first delivery after May 31, 1992, the day WGM's existing blanket import authorization expires.

A copy of this order is available for inspection and copying in the Office of

Fuels Programs Docket Room, 3F-056, Forrestal Building, 1000 Independence Avenue, SW., Washington, DC 20585, (202) 586-9478. The docket room is open between the hours of 8 a.m. and 4:30 p.m., Monday through Friday, except Federal holidays.

Issued in Washington, DC, May 29, 1992.

Charles F. Vacek,

Deputy Assistant Secretary for Fuels
Programs, Office of Fossil Energy.

[FR Doc. 92-13122 Filed 6-3-92; 8:45 am]

BILLING CODE 6450-01-M

Office of Hearings and Appeals

**Cases Filed During the Week of April
17 Through April 24, 1992**

During the Week of April 17 through April 24, 1992, the appeals and applications for exception or other relief listed in the appendix to this notice were filed with the Office of Hearings and Appeals of the Department of Energy. Submissions inadvertently omitted from earlier lists have also been included.

Under DOE procedural regulations, 10 CFR part 205, any person who will be aggrieved by the DOE action sought in these cases may file written comments on the application within ten days of service of notice, as prescribed in the procedural regulations. For purposes of the regulations, the date of service of notice is deemed to be the date of publication of this notice or the date of receipt by an aggrieved person of actual notice, whichever occurs first. All such comments shall be filed with the Office of Hearings and Appeals, Department of Energy, Washington, DC 20585.

Dated: June 1, 1992.

George B. Breznay,

Director, Office of Hearings and Appeals.

LIST OF CASES RECEIVED BY THE OFFICE OF HEARINGS AND APPEALS

[Week of April 17 through April 24, 1992]

Date	Name and location of applicant	Case No.	Type of submission
March 22, 1992	Gulf/Dick's Self Service, Milwaukee, WI	RR300-139	Request for Modification/Rescission in the Gulf Refund Proceeding. If Granted: The March 8, 1991 Decision and Order (Case No. RF300-8983) issued to Dick's Self Service regarding the firm's Application for Refund submitted in the Gulf refund proceeding would be modified.
April 17, 1992	Crescent Refining & Oil Co. and Petroleum Fuel Company, Washington, DC	LEF-0044	Implementation of Special Refund Procedures. If Granted: The Office of Hearings and Appeals would implement Special Refund Procedures pursuant to 10 C.F.R., Part 205, Subpart V, in connection with the September 18, 1991 Consent Judgement entered into with Crescent Refining & Oil Company and Petroleum Fuel Company.
Do.	Goodyear Tire & Rubber Company, Washington, DC	RR272-92	Request for Modification/Rescission in the Crude Oil Refund Proceeding. If Granted: The October 7, 1991 Decision and Order (Case No. RF272-20175) issued to Goodyear Tire & Rubber Company regarding the firm's Application for Refund submitted in the crude oil refund proceeding would be modified.

LIST OF CASES RECEIVED BY THE OFFICE OF HEARINGS AND APPEALS—Continued

[Week of April 17 through April 24, 1992]

Date	Name and location of applicant	Case No.	Type of submission
April 20, 1992.....	Enron/Texaco Refining and Marketing, Inc., St. Louis, MO.	RR340-1	Request for Modification/Rescission in the Enron Refund Proceeding. If Granted: The December 6, 1991 Decision and Order (Case No. RF340-25) issued to Texaco Refining and Marketing, Inc., regarding the firm's Application for Refund submitted in the Enron refund proceeding would be modified.
April 24, 1992.....	Gulf/Carolina Fuel Raleigh, NC.....	RR300-140	Request for Modification/Rescission in the Gulf Refund Proceeding. If Granted: The March 27, 1992 Decision and Order (Case No. RF300-59) issued to Carolina Fuel regarding a correction to the firm's Application for Refund submitted in the Gulf refund proceeding would be modified.

REFUND APPLICATIONS RECEIVED

Date received	Name of refund proceeding/name of refund applicant	Case No.
April 17, 1992.....	Vickers/Nebraska.....	RQ1-578
Do.....	Nat'l Helium/Nebraska.....	RQ3-579
Do.....	Coline/Nebraska.....	RQ2-580
Do.....	Standard Oil Ind (Amoco)/Nebraska.....	RQ251-581
April 17, 1992 thru April 24, 1992.....	Gulf Oil Refund Applications Received.....	RF300-19927 thru RF300-19960
Do.....	Atlantic Richfield Applications Received.....	RF304-12977 thru RF304-13002
Do.....	Texaco Refund Applications Received.....	RF321-18571 thru RF321-18589
April 20, 1992.....	Blandin Paper Company.....	RF340-114
Do.....	Growmark, Inc.....	RF340-115
April 21, 1992.....	Martin Oil Company.....	RF333-30
April 22, 1992.....	Liquegas.....	RF340-116
Do.....	Bonesteel Oil Company.....	RF340-117
April 23, 1992.....	Sooner Petroleum Company.....	RF340-118
Do.....	Three Allen Center.....	RF340-119
April 24, 1992.....	Energy Refunds, Inc.....	RF340-120
Do.....	Frankston Reliance Gas Company.....	RF340-121

[FR Doc. 92-13107 Filed 6-3-92; 8:45 am]

BILLING CODE 8450-01-M

Cases Filed During the Week of April 24 Through May 1, 1992

During the Week of April 24 through May 1, 1992, the appeals and applications for exception or other relief listed in the appendix to this notice were

filed with the Office of Hearings and Appeals of the Department of Energy.

Under DOE procedural regulations, 10 CFR part 205, any person who will be aggrieved by the DOE action sought in these cases may file written comments on the application within ten days of service of notice, as prescribed in the procedural regulations. For purposes of the regulations, the date of service of

notice is deemed to be the date of publication of this notice or the date of receipt by an aggrieved person of actual notice, whichever occurs first. All such comments shall be filed with the Office of Hearings and Appeals, Department of Energy, Washington, DC 20585.

Dated: May 28, 1992.

George B. Breznay,
Director, Office of Hearings and Appeals.

LIST OF CASES RECEIVED BY THE OFFICE OF HEARINGS AND APPEALS

[Week of April 24 through May 2, 1992]

Date	Name and location of applicant	Case No.	Type of submission
April 23, 1992.....	Tesoro/Defense Fuel Supply Center, Alexandria, VA.	RR326-1	Request for Modification/Rescission in the Tesoro Refund Proceeding. If Granted: The December 30, 1991 Decision and Order (Case No. RF326-310) issued to Defense Fuel Supply Center regarding the firm's Application for Refund submitted in the Tesoro refund proceeding would be modified.
April 24, 1992.....	Gulf/Gulfmain Service Center, Rye Brook, NY.....	RR300-142	Request for Modification/Rescission in the Gulf Refund Proceeding. If Granted: The March 30, 1992 Dismissal Letter (Case No. RF300-13532) issued to Gulfmain Service Center regarding the firm's Application for Refund submitted in the Gulf refund proceeding would be modified.
April 27, 1992.....	C. Parker Oil Company, Inc., Asheville, NC.....	LEE-0042	Except to the Reporting Requirements. If Granted: C. Parker Oil Company, Inc., would not be required to file Form EIA-672B, "Reseller/Retailer's Monthly Petroleum Product Sales Report."

List of Cases Received by the Office of Hearings and Appeals—Continued

[Week of April 24 through May 2, 1992]

Date	Name and location of applicant	Case No.	Type of submission
Do.....	Consolidated Edison Co. of New York, <i>et al</i> , Gladwyne, PA.	LER-0008	Request for Modification/Rescission. If Granted: The April 2, 1992 Decision and Order (Case No. KEF-0120) issued to the Consolidated Edison Co. of New York, <i>et al</i> , concerning a determination to extend the deadline for the submission of crude oil refund claims to June 30, 1994, would be rescinded.
Do.....	Gulf/Liverman's Gulf, Woodbridge, VA.....	RR300-141	Request for Modification/Rescission in the Gulf Refund Proceeding. If Granted: The April 6, 1992 Dismissal Letter issued to Liverman's Gulf regarding the firm's Application for Refund submitted the Gulf refund proceeding would be modified.
April 29, '92.....	ARCO/Alger Oil Company, Rising Sun, MD.....	RR304-38	Request for Modification/Rescission in the ARCO Refund Proceeding. If Granted: The April 8, 1992 Decision and Order (Case No. RR304-35) issued to Alger Oil Company in the Atlantic Richfield Company Subpart V special refund proceeding would be modified.
Do.....	Texaco/Stewart's Texaco, Shamrock, TX.....	RR321-112	Request for Modification/Rescission in the Texaco Refund Proceeding. If Granted: The April 1, 1992 Decision and Order (Case No. RF321-18499) issued to Stewart's Texaco regarding the firm's Application for Refund submitted in the Texaco refund proceeding would be modified.
April 30, 1992.....	Gulf/Hill's Gulf, Woodbridge, VA.....	RR300-144	Request for Modification/Rescission in the Gulf Refund Proceeding. If Granted: The April 6, 1992 dismissal of an Application for Refund filed by Hill's Gulf (Case No. RF300-13058) in the Gulf Oil Company special refund proceeding would be reviewed.
Do.....	Gulf/Kelly's Gulf, Woodbridge, VA.....	RR300-145	Request for Modification/Rescission in the Gulf Refund Proceeding. If Granted: The April 6, 1992 dismissal of an Application for Refund filed by Kelly's Gulf (Case No. RF300-13182) in the Gulf Oil special refund proceeding would be reviewed.
Do.....	Gulf/S&S Service Station, Deposit, NY.....	RR300-143	Request for Modification/Rescission in the Gulf Refund Proceeding. If Granted: The March 30, 1992 dismissal of an Application for Refund filed by the S&S Service Station (Case No. RF300-11720) in the Gulf Oil special refund proceeding would be modified.
May 1, 1992.....	James L. Schwab, Spokane, WA.....	LFA-0208	Appeal of an Information Request Denial. If Granted: James L. Schwab would receive a waiver of all fees incurred in the processing of his Freedom of Information Request for a videotape mailed to him on February 6, 1992.
Do.....	Consolidated Edison Company of New York, <i>et al</i> , New York, NY.	LER-0009	Request for Modification/Rescission. If Granted: The April 2, 1992 Decision and Order (Case No. LFX-0006) issued in the 341 Tract Unit of the Citronelle Field proceeding to entertain claims for refunds from Farmer Cooperatives and Airlines who executed waivers and releases in <i>The Department of Energy Stripper Well Exemptions Litigation</i> would be modified.
Do.....	341 Tract Unit of the Citronelle Field, Washington, DC.	LER-0010	Request for Modification/Rescission. If Granted: The December 24, 1991 Decision and Order (Cases Nos. HER-0050, HER-0106 and KEZ-0096) issued to the 341 Tract Unit of the Citronelle Field regarding the termination of previously granted exception relief would be modified.

REFUND APPLICATIONS RECEIVED

Date received	Name of refund proceeding/name of refund applicant	Case No.
April 24, 1992 thru May 1, 1992.....	Crude Oil, Applications Received.....	RF272-92217 thru RF272-92250
Do.....	Atlantic Richfield, Applications Received.....	RF304-13003 thru RF304-13021
Do.....	Enron Oil, Applications Received.....	RF304-122 thru RF340-161
April 27, 1992.....	Reagan Auto Service.....	RF343-8
Do.....	Jack's Service.....	RF342-201
Do.....	ACF Industries, Inc.....	RF300-19961
Do.....	City of Benbrook.....	RF300-19962
Do.....	Broadway-Yellow Cab Co., Inc.....	RF300-19963
Do.....	City of Central Falls.....	RF300-19964
Do.....	Cherokee County.....	RF300-19965
Do.....	Stewart & Stevenson Services.....	RF300-19966
Do.....	Bubb's Gulf.....	RF300-19967
Do.....	Westbank Texaco.....	RF321-18587
Do.....	Carriage Trade Car Wash.....	RF321-18590
Do.....	Chama Texaco.....	RF321-18591
Do.....	Gene's Texaco Service.....	RF321-18592
Do.....	Palagyi's Texaco.....	RF321-18593
Do.....	Melini's Texaco.....	RF321-18594

REFUND APPLICATIONS RECEIVED—Continued

Date received	Name of refund proceeding/name of refund applicant	Case No.
April 28, 1992	City of New York	RA272-50
Do.	Albert J. Szoke	RF342-202
Do.	D & J Car Wash	RF300-19968
April 29, 1992	Drakes Texaco	RF321-18595
Do.	Rasmussen Fuel Company, Inc.	RF342-203
Do.	The Circle K Corporation	RF300-19969
April 30, 1992	Dave Walters Texaco	RF321-18596

[FR Doc. 92-13123 Filed 6-3-92; 8:45 am]
BILLING CODE 6450-01-M

Issuance of Decisions and Orders During the Week of April 20 Through April 24, 1992

During the week of April 20 through April 24, 1992, the decisions and orders summarized below were issued with respect to appeals and applications for other relief filed with the Office of Hearings and Appeals of the Department of Energy. The following summary also contains a list of submissions that were dismissed by the Office of Hearings and Appeals.

Appeals

David Dekok, 4/21/92, LFA-0199

On March 23, 1992, David DeKok filed an Appeal from a February 26, 1992, determination issued by the San Francisco Field Office (SFO) of the Department of Energy (DOE) in response to a request for documents that Dekok had made under the Freedom of Information Act (FOIA). In considering the Appeal, the DOE found that SFO had met the requirements of the FOIA by making the responsive documents available for the requestor's review at the Lawrence Livermore National Laboratories and that it had made an adequate search for responsive documents. However, SFO was directed to issue a new determination concerning whether a certain document that it had discovered pursuant to the Appeal was responsive to the Appellant's request.

James L. Schwab, 4/23/92, LFA-0200

James L. Schwab (Schwab) filed an Appeal from a determination issued to him by the Department of Energy Field Office, Albuquerque (DOE/AL) in response to a request for information made by Mr. Schwab under the Freedom of Information Act (FOIA). Mr. Schwab, a former employee of a DOE contractor, had requested all documents regarding the DOE's investigations into allegations made by Schwab concerning: (1) Illegal telephone use by contractor employees at the Tonapah Test Range (TTR); (2) the use of material which originated in

South Africa at TTR; and (3) the possible sighting of endangered species at TTR. In its March 16, 1992, determination, DOE/AL provided Schwab with copies of three documents regarding illegal telephone use, and two other documents regarding the possible sighting of endangered species. Schwab appealed the adequacy of DOE/AL's search and determination. In considering the Appeal, the DOE found that DOE/AL's case file indicated that Sandia National Laboratories had been contacted to provide documents responsive to Schwab's request. However, because of personnel changes at DOE/AL, it could not be determined whether other offices or individuals were contacted. Based on the information provided by DOE/AL, the DOE was unable to determine whether the search conducted was adequate or reasonably calculated to uncover the material sought by the Appellant. Consequently, the DOE remanded the matter to DOE/AL to conduct a new search for all documents responsive to Schwab's request.

Seattle Post-Intelligencer, 4/24/92, LFA-0205

On April 16, 1992, the Seattle Post-Intelligencer (SPI) filed an Appeal from a determination issued by the Bonneville Power Administration (BPA) in response to a request for documents made by SPI under the Freedom of Information Act (FOIA). In that determination, BPA denied a request for a copy of a settlement agreement between the Washington Public Power Supply System and the General Electric Company on the basis that the document was the subject of a confidentiality order issued by the United States District Court for the Eastern District of Washington. The order specifically directed BPA not to release the settlement agreement. The DOE found clear Supreme Court authority stating that the FOIA does not require an agency to commit contempt of court in order to release documents in order to comply with the provisions of the FOIA. Accordingly, the Appeal was denied.

Thomas Williams, 4/24/92, LFA-0204

Thomas Williams filed an Appeal from a denial by the Department of Energy Office of Inspector General of a request for information submitted by Mr. Williams under the Freedom of Information Act (FOIA). Because some of the documents responsive to Williams' request related to matters under investigation by the IG, certain materials were withheld pursuant to FOIA Exemption 7(A), which shields from disclosure "records or information compiled for law enforcement purposes, but only to the extent that the production of such law enforcement records or information (A) could reasonably be expected to interfere with enforcement proceedings * * * 5 U.S.C. 552(b)(7)(A). However, subsequent to the IG's determination, the investigation was completed. The matter was therefore remanded to the IG for a determination on whether the requested documents should be released or are exempt from mandatory disclosure pursuant to another FOIA exemption.

Refund Applications

Texaco, Inc./Westgate Texaco, 4/22/92, RR321-75

James R. Allen, the owner of Westgate Texaco, filed a Motion for Reconsideration of a Decision and Order that denied duplicate Texaco refund applications that had been filed on his behalf by a private firm, Federal Refunds, Inc. (FRI). In the Motion, Mr. Allen stated that he had signed the second application, and certified in it that no other application had been filed, because he had been informed by FRI that the first application had been lost and had not been filed. In considering the Motion, the DOE found that the erroneous filing of the duplicate applications was solely caused by FRI. The DOE also found that Mr. Allen had reasonable grounds for believing that the second application, which he signed, would be the only application filed by FRI. Accordingly, the Motion for Reconsideration was approved and Mr. Allen was granted a refund of \$5,084.

Texas Industries, Inc., 4/23/92, RF272-26852, RD272-26852

The DOE issued a Decision and Order granting an Application for Refund filed by Texas Industries, Inc., a manufacturer of construction materials, in the Subpart V crude oil special refund proceeding. A group of states and territories (States) objected to the Application on the grounds that the Applicant was able to pass through increased petroleum costs to its customers. In support of their objection, the States submitted an affidavit of an economist stating that, in general, the cement industry was able to pass through increased petroleum costs. The DOE determined that the evidence offered by the States was insufficient to rebut the presumption of end-user injury and that the Applicant should receive a refund. The DOE also denied the States' Motion for Discovery, finding that discovery was not warranted where the States had not presented evidence sufficient to rebut the Applicant's

presumption of injury. The refund granted to the Applicant in this Decision was \$32,668.

Vickers Energy Corp./Kansas, 4/23/92, RQ1-575, RQ1-576, RQ1-577

The DOE issued a Decision and Order approving, in part, the second-stage applications filed by the State of Kansas in the Vickers Energy Corporation special refund proceeding. Kansas requested permission to use \$390,000 to purchase and install new laundry equipment at the Topeka State Hospital, \$69,704 to install a telecommunications link between Parsons State Hospital and the University of Kansas, \$303,476 to replace eleven vans for the transportation of the State's elderly, \$149,473 to purchase new kitchen equipment for State institutions for the elderly and \$20,801 to purchase new vans for the Beloit youth center. The DOE found that, when considered as part of Kansas' overall oil overcharge restitution program, its plans to install a

telecommunication link, to purchase new vans for the elderly and to purchase new vans for the Beloit youth warrant approval. The DOE denied Kansas' request to use Vickers' monies to fund the purchasing of new laundry equipment and kitchen equipment. Second-stage refunds monies should be used to supplement but not supplant State, local, or any other funds available for the designated programs. On the basis of the information available, DOE determined that the old laundry and kitchen equipment could be replaced pursuant to an existing, regularly budgeted program.

Refund Applications

The Office of Hearings and Appeals issued the following Decisions and Orders concerning refund applications, which are not summarized. Copies of the full texts of the Decisions and Orders are available in the Public Reference Room of the Office of Hearings and Appeals.

American Samoa Power Authority.....	RF272-66564	04/22/92
Atlantic Richfield Company/Bogata Gas Co. et al.....	RF304-9293	04/20/92
Atlantic Richfield Company/Winsome Arco.....	RF304-149	04/22/92
Silver Arco.....	RF304-12840	
Acme Arco.....	RF304-12841	
Serramonte Arco.....	RF304-12842	
Fort Howard Cup Corporation.....	RF272-69564	04/22/92
Fort Howard Cup Corporation.....	RD272-69564	
Gulf Oil Corporation/Dinkins Service, Inc. et al.....	RR330-121	04/22/92
Occidental Chemical Corp.....	RF272-44117	04/20/92
Occidental Chemical Corp.....	RD272-44117	
Occidental Chemical Corp.....	RF272-63961	
Quantum Chemical Corporation/Lascelles Oil Co. et al.....	RF330-54	04/24/92
Texaco Inc./Felicia Oil Co., Inc. et al.....	RF321-7068	04/20/92
Texaco Inc./Russell Moody's Texaco et al.....	RF321-462	04/22/92
Texaco Inc./Williams' Texaco.....	RF321-1979	04/20/92
Girton's Texaco Service.....	RF321-11848	
Texaco, Inc./Benoit's Texaco et al.....	RF321-812	04/23/92
Texaco, Inc./Charlie Fambro Service Center et al.....	RF321-10273	04/23/92
Texaco, Inc./James Maler Texaco et al.....	RF321-3203	04/24/92
United Refining Company/Martin Oil Co.....	RF333-30	04/21/92

Dismissals

The following submissions were dismissed:

Name	Case No.
A.J. Miller Trucking Co.....	RF300-13897
Al's Texaco.....	RF321-09280
Alps Texaco.....	RF321-09388
B & H Distributors.....	RF321-9954
Bob Kern's Texaco.....	RF321-07289
Boulevard Texaco.....	RF321-12426
Brighton Texaco.....	RF321-16360
Chadwick South Texaco.....	RF321-07188
Charlie's Texaco.....	RF321-07306
Chevron U. S. A., Inc.....	RF324-4
Clint's Gulf.....	RF300-13611
Community Texaco.....	RF321-09285
Community Texaco.....	RF321-02211
Crow Foot Gulf.....	RF300-13942
Dave's Texaco.....	RF321-02223

Name	Case No.	Name	Case No.
Del's Gulf.....	RF300-13955	Johnny's Texaco.....	RF321-07290
Donati's Texaco.....	RF321-07194	Kelley's Texaco.....	RF321-5897
E & J Tacoma St. Service.....	RF321-07168	Kiln Supermarket, Inc.....	RF300-13609
Elrod Gulf Service Station.....	RF300-13636	Kingman Truck Terminal.....	RF315-9988
Exton Arco.....	RF304-12786	LA Gloria Oil & Gas Co.....	RF340-45
Five Point Texaco.....	RF321-09279	Lacey Springs Gulf.....	RF300-13929
Fork's Texaco.....	RF321-07172	Lewis Big Gulf.....	RF300-13619
Fran Miller's Texaco.....	RF321-07181	Lewis Dukes Gulf.....	RF300-108
Frank Newcomb Texaco.....	RF321-07165	Lilburn Texaco.....	RF321-09202
Fraser Texaco.....	RF321-07305	Lord's Texaco.....	RF321-09203
Gene's Texaco.....	RF321-5213	Lucas Funeral Home.....	RF300-13922
Harry Berkovich Texaco.....	RF321-347	Lyons Construction Company.....	RF300-13923
Haynes Texaco.....	RF321-355	McLain's Texaco #1 and #2.....	RF321-689
Hibdon's Texaco.....	RF321-371	McLain's Texaco #1 and #2.....	RF321-688
Hilltop Texaco.....	RF321-9923	Mondello's Brothers Service.....	RF321-07301
Ingram Texaco.....	RF321-9927	Moore's Texaco #1 and #2.....	RF321-379
Intercounty Construction.....	RF300-12933	Moore's Texaco #1 and #2.....	RF321-380
J.C. O'Dillon Texaco.....	RF321-09387	Morales Brothers Texaco.....	RF321-5335
Jack's Service Station.....	RF321-07298	Morgan Texaco.....	RF321-07304
Jerry Lowman Texaco.....	RF321-17411	Mosso's Texaco Service.....	RF321-390
Jim's Gulf in Amity.....	RF300-13886	Nelson's Texaco Station.....	RF321-12404

Name	Case No.
Petlak & Sons Texaco	RF321-07173
R & W Texaco	RF321-07174
Roland's Texaco	RF321-07302
Royal Gulf	RF300-13613
Russ' Gulf	RF300-13691
Russell's Texaco #1 and #2	RF321-464
Russell's Texaco #1 and #2	RF321-463
Samih Khatib Service Station	RF300-13997
Schatz Texaco	RF321-07180
Sheridan Fruitwood Texaco	RF321-09286
Shively's Texaco Service	RF321-07292
Smith Texaco of Niagara Falls	RF321-511
Smith Texaco Self Service	RF321-510
Soo Oil Company	RF300-13604
South Brothers Gulf Station	RF300-13635
South Main Texaco	RF321-516
Southeastern Transfer and Storage	RF300-13687
Southland Gulf Super Service	RF300-11616
Speight's Texaco	RF321-532
Tex-Amart #2	RF321-07169
Texaco Copia & Gateway West	RF321-9952
Turnpike Texaco	RF321-07297
Vic's Texaco	RF321-07300
Walt's Texaco	RF321-07189
Westhill Gulf	RF300-13887
White's Texaco	RF321-09386
Zerbey's Texaco	RF321-09281

Copies of the full text of these decisions and orders are available in the Public Reference Room of the Office of Hearings and Appeals, room 1E-234, Forrestal Building, 1000 Independence Avenue, SW., Washington, DC 20585, Monday through Friday, between the hours of 1 p.m. and 5 p.m., except federal holidays. They are also available in Energy Management: Federal Energy Guidelines, a commercially published loose leaf reporter system.

Dated: May 28, 1992.

George B. Breznay,
Director, Office of Hearings and Appeals.
[FR Doc. 92-13124 Filed 6-3-92; 8:45 am]
BILLING CODE 6450-01-M

ENVIRONMENTAL PROTECTION AGENCY

[FRL 4139-3]

Agency Information Collection Activities Under OMB Review

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*), this notice announces that the Information Collection Request (ICR) abstracted below has been forwarded to the Office of Management and Budget (OMB) for review and comment. The ICR describes the nature of the information collection and its expected cost and burden; where appropriate, it includes the actual data collection instrument.

DATES: Comments must be submitted on or before July 6, 1992.

FOR FURTHER INFORMATION OR TO OBTAIN A COPY OF THIS ICR, CONTACT: Sandy Farmer at EPA, (202) 260-2740, **SUPPLEMENTARY INFORMATION:**

Office of Air and Radiation

Title: Baseline Request on the Production, Transformation, Import and Export of Methyl Bromide. (EPA ICR #1432.10; OMB #2060-0170). This ICR is an amendment to an existing clearance.

Abstract: The EPA is currently developing regulations proposing to add methyl bromide to the list of class I ozone-depleting substances under section 602 of the Clean Air Act Amendments of 1990. The Agency is requesting clearance to collect baseline information on methyl bromide for 1991 from producers, transformers, importers and exporters of the substance. The information requested is identical to the Agency's November 26, 1990 request for baseline data for certain ozone-depleting substances (55 FR 49116). The Agency will use the information to establish baselines for methyl bromide producers, transformers, importers and exporters and to allot production, consumption and transformation allowances for methyl bromide.

Burden Statement: The public reporting burden for this one-time collection of information is estimated to average 8 hours per response, including time for reviewing instructions, searching existing data sources, gathering the data needed, and completing and reviewing the collection of information.

Respondents: Methyl bromide producers, transformers, importers and exporters

Estimated Number of Respondents: 12

Estimated Total Annual Burden on

Respondents: 96 hours

Frequency of Collection: One-time

Send comments regarding the burden estimate, or any other aspect of this information collection, including suggestions for reducing the burden, to:

Sandy Farmer, U.S. Environmental Protection Agency, Information Policy Branch (PM-223), 401 M Street, SW., Washington, DC 20460

and
Troy Hillier, Office of Management and Budget, Office of Information and Regulatory Affairs, 725 17th Street, NW., Washington, DC 20503

Dated: May 28, 1992.

Paul Lapsley,
Director, Regulatory Management Division.
[FR Doc. 92-13098 Filed 6-3-92; 8:45 am]

BILLING CODE 6560-50-M

[FRL 4139-4]

Science Advisory Board, Environmental Engineering Committee, Indoor Air Engineering Research Subcommittee, Open Meeting

Pursuant to the Federal Advisory Committee Act, Public Law 92-463, notice is hereby given that the Science Advisory Board's (SAB's) Indoor Air Engineering Research Subcommittee (IAERS) of the Environmental Engineering Committee (EEC), will meet on Monday, July 20, and Tuesday, July 21, 1992. The meeting will be at the U.S. Environmental Protection Agency (EPA) Air and Energy Engineering Research Laboratory (AEERL) at Research Triangle Park, North Carolina 27711. The meeting will begin at 9 am on Monday, July 20th and 8:30 am on Tuesday, July 21st and will adjourn no later than 4 pm on July 21st.

At this meeting, the IAERS will receive briefings from Agency staff, and comment on the draft report on the Agency's Indoor Air Engineering Research Program which was prepared by the Agency's Office of Research and Development (ORD) staff. Copies of this draft report on the Agency's Indoor Air Engineering Research Program may be obtained by contacting Ms. Carolyn Fowler, Secretary to the Pollution Control Division, ORD at the U.S. EPA's AEERL, Research Triangle Park, North Carolina 27711 at (919) 541-2915.

The proposed charge to the SAB's IAERS from the Agency's ORD is to address the overall indoor air engineering research program, to evaluate research-in-progress, as well as strategic planning and strategic directions issues. The following questions are being asked of the SAB/IAERS: (1) Is the EPA/ORD approach to source characterization, with its focus on developing methods for characterizing emissions, sink effects, and exposures, a rational and scientifically sound approach? (2) Is the EPA/ORD approach to indoor air quality (IAQ) modeling and evaluation of IAQ control techniques sufficiently rigorous and appropriately practical? (3) Are the EPA/ORD projects and plans for developing guidance on microbial contaminant control reasonable and scientifically sound? (4) Is bioresponse-based testing of emissions from sources a reasonable extension of chemically-based testing? Is it likely to provide a better measure of the potential of indoor sources to cause health and comfort problems in buildings? and (5) Is there any aspect of the strategic direction of

the indoor air engineering research program that should be reevaluated?

The meeting is open to the public and seating will be on a first come basis. Any member of the public wishing further information, such as a proposed agenda on the meeting should contact Dr. K. Jack Kooyoomjian, Designated Federal Official, or Mrs. Diana L. Pozun, Secretary, Science Advisory Board (A101F), U.S. Environmental Protection Agency, Washington, DC 20460, at 202/260-6552. Written comments received by July 6, 1992 will be mailed to the SAB/IAERS; comments received after that date will be provided to the IAERS at the meeting. Written comments of any length (at least 35 copies) may be provided to the Subcommittee up until the meeting.

Members of the public who wish to make a brief oral presentation should contact Dr. K. Jack Kooyoomjian no later than July 2, 1992. The Science Advisory Board expects that public statements presented at its meetings will not be repetitive of previously submitted oral or written statements. In general, each individual or group making an oral presentation will be limited to a total time of five minutes.

Dated: May 21, 1992.

Donald G. Barnes,

Staff Director, Science Advisory Board (A101F).

[FR Doc. 92-13097 Filed 6-3-92; 8:45 am]

BILLING CODE 6560-50-M

Superfund Remedial Branch, Proposed Administrative Settlement; Baxter/Union Pacific Tie Treating Site, Laramie, WY

[FRL 4139-5]

AGENCY: U.S. Environmental Protection Agency (EPA).

ACTION: Proposed administrative settlement.

SUMMARY: In accordance with the requirements of section 122(i) of the Comprehensive Environmental Response, Compensation, and Liability Act, as amended (CERCLA), notice is hereby given of a proposed administrative settlement under section 122(h) concerning the Baxter/Union Pacific Tie Treating Site in Laramie, Wyoming (Site). The proposed administrative settlement requires one potentially responsible party (PRP) to pay \$237,996.12 in order to resolve the United States' cost recovery claim related to response activities taken by EPA in connection with the Site.

DATES: Comments must be submitted by July 6, 1992.

ADDRESSES: Comments should be addressed to Geniene R. Hillier (8HWM-SR), Enforcement Specialist, U.S. Environmental Protection Agency, Region VIII, 999 18th Street, suite 500, Denver, Colorado 80202-2405, and should refer to: In the matter of Baxter/Union Pacific Tie Treating Site, Laramie, Wyoming.

FOR FURTHER INFORMATION CONTACT: Eduardo Quintana, Assistant Regional Counsel, Office of Regional Counsel, at (303) 293-1458.

SUPPLEMENTARY INFORMATION: Notice of section 122(h) Cost Recovery Settlement:

In accordance with section 122(i) of CERCLA, notice is hereby given that the terms of an Administrative Settlement Agreement (CERCLA-VIII-92-14) have been agreed to by the Union Pacific Railroad Company. In accordance with section 122(h)(1) of CERCLA, EPA has obtained the prior written approval from the Department of Justice to settle the United States claim under section 107(a) of CERCLA for past response costs incurred from September 30, 1986 to November 30, 1991. By the terms of the administrative settlement, this PRP will pay \$237,996.12 to EPA if the United States will provide Union Pacific with a limited covenant not to sue for reimbursement of response and oversight costs incurred by the United States after September 30, 1986 and prior to November 30, 1991 in connection with Site. The \$237,996.12 figure represents 100% of the total costs expended by EPA from September 30, 1986, to November 30, 1991, in connection with response activities undertaken to implement a 1986 Record of Decision and investigations addressing further remediation of the Site.

EPA will receive, for a period of thirty (30) days from the date of this publication, comments relating to the proposed administrative settlement.

A copy of the proposed Administrative Settlement Agreement may be obtained in person or by mail from Eduardo Quintana (8RC), Assistant Regional Counsel, U.S. Environmental Protection Agency, Region VIII, 999 18th Street, suite 500, Denver, Colorado 80202-2405. Additional background information relating to the administrative settlement is available for review at that address.

Dated: May 26, 1992.

Robert L. Duprey,

Director, Hazardous Waste Management Division.

[FR Doc. 92-13096 Filed 6-3-92; 8:45 am]

BILLING CODE 6560-50-M

FEDERAL COMMUNICATIONS COMMISSION

[DA 92-637]

Reporting Requirements for International Traffic Data

AGENCY: Federal Communications Commission.

ACTION: Notice.

SUMMARY: FCC is making available for comments a Manual for filing § 43.61 Data. The Commission recently revised and simplified its requirements for reporting international traffic data. The revisions will reduce the burden on carriers and improve the quality of data received by the Commission.

DATES: Comments must be filed on or before June 19, 1992 and reply comments must be filed on or before July 6, 1992.

ADDRESSES: To file formally in this proceeding, participants must file an original and four copies of all comments and reply comments with the Secretary, Federal Communications Commission, Washington, DC 20554.

FOR FURTHER INFORMATION CONTACT: Linda Blake or Jim Lande, Common Carrier Bureau, Industry Analysis Division, (202) 632-0745.

SUPPLEMENTARY INFORMATION:

Release Date: May 22, 1992.

Comment Dates Established Reporting Requirements for International Traffic Data

Comment Date: June 19, 1992
Reply Date: July 6, 1992.

The Commission has revised and simplified its requirements for reporting international traffic data. Report and Order, CC Docket No. 91-22, Released February 12, 1992. A Manual for Filing § 43.61 Data, dated May 1992, is being made available for notice and comment.

The manual implements the Commission's decision to eliminate obsolete reporting requirements. Other changes include the incorporation of data for Canada, and Saint Pierre and Miquelon, and Mexico; streamlined requirements for pure resellers; a revised definition of minutes to be filed; the addition of two categories of private line service; and, the reporting of new service revenues. The manual also provides a new data format to speed processing. These revisions will reduce the burden on carriers and improve the quality of data received by the Commission.

An original and four copies of comments and reply comments on the Manual for Filing § 43.61 Data should be filed with the Office of the Secretary,

1919 M St. NW., Washington, DC, 20554, room 222. Comments must be filed by June 19, 1992. Reply comments must be filed by July 6, 1992.

All carriers that provided international service in 1991, including pure resale carriers, must file 1991 international traffic data in compliance with the current § 43.61 of the Rules. Carriers may use the new reporting procedures on an interim basis for reporting 1991 data.

The manual is available for reference in the Industry Analysis Division Reference Room, Common Carrier Bureau, 1250 23rd Street, NW., Plaza Level. Copies may be purchased by calling Downtown Copy Center (DCC) at (202) 452-1422. For more information contact Linda Blake or Jim Lande of the Industry Analysis Division at 202-632-0745.

Federal Communications Commission.

Donna R. Searcy,

Secretary.

[FR Doc. 92-12935 Filed 6-3-92; 8:45 am]

BILLING CODE 6712-01-M

FEDERAL EMERGENCY MANAGEMENT AGENCY

[FEMA-942-DR]

California; Major Disaster and Related Determinations

AGENCY: Federal Management Agency (FEMA).

ACTION: Notice.

EFFECTIVE DATE: May 2, 1992.

SUMMARY: This is a notice of the Presidential declaration of a major disaster for the State of California (FEMA-942-DR), dated May 2, 1992, and related determinations.

FOR FURTHER INFORMATION CONTACT: Neva K. Elliott, Disaster Assistance Programs, Federal Emergency Management Agency, Washington, DC 20472, (202) 646-3614.

SUPPLEMENTARY INFORMATION: Notice is hereby given that, in a letter dated May 2, 1992, the President declared a major disaster under the authority of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5121 *et seq.*), as follows:

I have determined that the damage in the City of Los Angeles and Los Angeles County (State of California), resulting from fires during a period of civil unrest beginning on April 29, 1992, is of sufficient severity and magnitude to warrant a major disaster declaration under the Robert T. Stafford Disaster Relief and Emergency Assistance Act ("the Stafford Act"). I, therefore, declare that such a major disaster exists in the City

of Los Angeles and the County of Los Angeles, in the State of California.

In order to provide Federal assistance, you are hereby authorized to allocate from funds available for these purposes, such amounts as you find necessary for Federal disaster assistance and administrative expenses.

You are authorized to provide Individual Assistance and Public Assistance in the designated areas. Consistent with the requirement that Federal assistance be supplemental, any Federal funds provided under the Stafford Act for Public Assistance will be limited to 75 percent of the total eligible costs.

The time period prescribed for the implementation of section 310(a), Priority to Certain Applications for Public Facility and Public Housing Assistance, 42 U.S.C. 5153, shall be for a period not to exceed six months after the date of this declaration.

Notice is hereby given that pursuant to the authority vested in the Director of the Federal Emergency Management Agency under Executive Order 12148, I hereby appoint William M. Medigovich of the Federal Emergency Management Agency to act as the Federal Coordinating Officer for this declared disaster.

I do hereby determine the following areas of the State of California to have been affected adversely by this declared major disaster:

Los Angeles County for Individual Assistance and Public Assistance.

(Catalog of Federal Domestic Assistance No. 83.516, Disaster Assistance)

Wallace E. Stickney,

Director.

[FR Doc. 92-12991 Filed 6-3-92; 8:45 am]

BILLING CODE 6718-02-M

FEDERAL MARITIME COMMISSION

United States/Middle East and Indian Subcontinent Interconference; Agreement(s) Filed

The Federal Maritime Commission hereby gives notice of the filing of the following agreement(s) pursuant to section 5 of the Shipping Act of 1984.

Interested parties may inspect and obtain a copy of each agreement at the Washington, DC Office of the Federal Maritime Commission, 1100 L Street NW., room 10325. Interested parties may submit comments on each agreement to the Secretary, Federal Maritime Commission, Washington, DC 20573, within 10 days after the date of the **Federal Register** in which this notice appears. The requirements for comments are found in § 572.603 of title 46 of the Code of Federal Regulations. Interested persons should consult this section before communicating with the

Commission regarding a pending agreement.

Agreement No.: 206-011377.

Title: United States/Middle East and Indian Subcontinent Interconference Agreement.

Parties:

The "8900" Lines,
The West Coast/Middle East Rate Agreement,
A.P. Moller-Maersk Line,
American President Lines, Ltd.,
National Shipping Company of Saudi Arabia,
Sea-Land Service, Inc.,
United Arab Shipping Company (S.A.G.),
Waterman Steamship Corporation.

Synopsis: The proposed Agreement will authorize the parties to discuss and agree upon rates, charges, rules, and terms and conditions of service, and to exchange information in the trade from United States ports and points (excluding ports in Alaska and Hawaii) to ports and points in the Red Sea, Arabian Gulf and the Indian Subcontinent.

By order of the Federal Maritime Commission.

Dated: May 29, 1992.

Joseph C. Polking,

Secretary.

[FR Doc. 92-12999 Filed 6-3-92; 8:45 am]

BILLING CODE 6730-01-M

FEDERAL RESERVE SYSTEM

John Horace Day; Change in Bank Control Notice; Acquisition of Shares of Banks or Bank Holding Companies

The notificant listed below has applied under the Change in Bank Control Act (12 U.S.C. 1817(j)) and § 225.41 of the Board's Regulation Y (12 CFR 225.41) to acquire a bank or bank holding company. The factors that are considered in acting on notices are set forth in paragraph 7 of the Act (12 U.S.C. 1817(j)(7)).

The notice is available for immediate inspection at the Federal Reserve Bank indicated. Once the notice has been accepted for processing, it will also be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing to the Reserve Bank indicated for the notice or to the offices of the Board of Governors. Comments must be received not later than June 24, 1992.

A. Federal Reserve Bank of Atlanta
(Robert E. Heck, Vice President) 104 Marietta Street, NW., Atlanta, Georgia 30303;

1. John Horace Day, Orlando, Florida; to retain 9.02 percent and to acquire an additional 6.90 percent, for a total of 29.99 percent, of the voting shares of Orange Banking Corporation, Orlando, Florida, and thereby indirectly acquire Orange Bank, Orlando, Florida.

Board of Governors of the Federal Reserve System, May 29, 1992.

William W. Wiles,

Secretary of the Board.

[FR Doc. 92-13055 Filed 6-3-92; 8:45 am]

BILLING CODE 6210-01-F

Story County Bancorporation, et al.; Notice of Applications to Engage de novo in Permissible Nonbanking Activities

The companies listed in this notice have filed an application under § 225.23(a)(1) of the Board's Regulation Y (12 CFR 225.23(a)(1)) for the Board's approval under section 4(c)(8) of the Bank Holding Company Act (12 U.S.C. 1843(c)(8)) and § 225.21(a) of Regulation Y (12 CFR 225.21(a)) to commence or to engage de novo, either directly or through a subsidiary, in a nonbanking activity that is listed in § 225.25 of Regulation Y as closely related to banking and permissible for bank holding companies. Unless otherwise noted, such activities will be conducted throughout the United States.

Each application is available for immediate inspection at the Federal Reserve Bank indicated. Once the application has been accepted for processing, it will also be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing on the question whether consummation of the proposal can "reasonably be expected to produce benefits to the public, such as greater convenience, increased competition, or gains in efficiency, that outweigh possible adverse effects, such as undue concentration of resources, decreased or unfair competition, conflicts of interests, or unsound banking practices." Any request for a hearing on this question must be accompanied by a statement of the reasons a written presentation would not suffice in lieu of a hearing, identifying specifically any questions of fact that are in dispute, summarizing the evidence that would be presented at a hearing, and indicating how the party commenting would be aggrieved by approval of the proposal.

Unless otherwise noted, comments regarding the applications must be received at the Reserve Bank indicated or the offices of the Board of Governors not later than June 29, 1992.

A. Federal Reserve Bank of Chicago (David S. Epstein, Vice President) 230 South LaSalle Street, Chicago, Illinois 60690:

1. Story County Bancorporation, Jewell, Iowa; to acquire a 99 percent limited partnership interest in Viking Village Company, L.P., Jewell, Iowa, and thereby engage de novo in the provision of housing for low- and moderate-income families, pursuant to § 225.25(b)(6) of the Board's Regulation Y.

B. Federal Reserve Bank of Kansas City (John E. Yorke, Senior Vice President) 925 Grand Avenue, Kansas City, Missouri 64198:

1. The Avoca Company, Avoca, Nebraska; to engage de novo in community development activities, pursuant to § 225.25(b)(6) of the Board's Regulation Y.

Board of Governors of the Federal Reserve System, May 29, 1992.

William W. Wiles,

Secretary of the Board.

[FR Doc. 92-13052 Filed 6-3-92; 8:45 am]

BILLING CODE 6210-01-F

Tomoka Bancorp, Inc.; Formation of, Acquisition by, or Merger of Bank Holding Companies

The company listed in this notice has applied for the Board's approval under section 3 of the Bank Holding Company Act (12 U.S.C. 1842) and § 225.14 of the Board's Regulation Y (12 CFR 225.14) to become a bank holding company or to acquire a bank or bank holding company. The factors that are considered in acting on the applications are set forth in section 3(c) of the Act (12 U.S.C. 1842(c)).

The application is available for immediate inspection at the Federal Reserve Bank indicated. Once the application has been accepted for processing, it will also be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing to the Reserve Bank indicated for that application or to the offices of the Board of Governors. Any comment on an application that requests a hearing must include a statement of why a written presentation would not suffice in lieu of a hearing, identifying specifically any questions of fact that are in dispute and summarizing the evidence that would be presented at a hearing.

Comments regarding this application must be received not later than June 29, 1992.

A. Federal Reserve Bank of Atlanta (Robert E. Heck, Vice President) 104

Marietta Street, NW., Atlanta, Georgia 30303:

1. Tomoka Bancorp, Inc., Ormond Beach, Florida; to become a bank holding company by acquiring 100 percent of the voting shares of Tomoka State Bank, Ormond Beach, Florida.

Board of Governors of the Federal Reserve System, May 29, 1992.

William W. Wiles,

Secretary of the Board.

[FR Doc. 92-13053 Filed 6-3-92; 8:45 am]

BILLING CODE 6210-01-F

GENERAL ACCOUNTING OFFICE

Federal Accounting Standards Advisory Board; Meeting

AGENCY: General Accounting Office.

ACTION: Notice.

SUMMARY: Pursuant to section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. No. 92-463), as amended, notice is hereby given that the monthly meeting of the Federal Accounting Standards Advisory Board will be held on Thursday, June 18, 1992 from 9 a.m. to 4 p.m. in room 7313 of the General Accounting Office, 441 G Street NW., Washington, DC.

The agenda for the meeting will consist of a review of the minutes of the May 28-29 meeting, a discussion on Uses and Objectives of Federal Accounting, and a discussion on Liabilities and Other Commitments. We advise that other items may be added to the agenda; interested parties should contact the Staff Director for more specific information and to confirm the date of the meeting.

Any interested person may attend the meeting as an observer. Board discussions and reviews are open to the public.

FOR FURTHER INFORMATION CONTACT: Ronald S. Young, Staff Director, 401 F Street NW., room 302, Washington, DC 20001, or call (202) 504-3336.

Authority: Federal Advisory Committee Act, Pub. L. No. 92-463, Section 10(a)(2), 86 Stat. 770, 774 (1972) (current version at 5 U.S.C. app. section 10(a)(2) (1988); 41 CFR 101-6.1015 (1990).

Dated: May 29, 1992.

Ronald S. Young,

Staff Director.

[FR Doc. 92-13057 Filed 6-3-92; 8:45 am]

BILLING CODE 1610-01-M

GENERAL SERVICES ADMINISTRATION

Specifications for Electronic Price Sale Catalog

AGENCY: Federal Supply Service (GSA).

ACTION: Notice.

SUMMARY: The Federal Supply Service (FSS) of the General Services Administration has developed a set of specifications, consistent with the American National Standards Institute (ANSI) X12 Standards for Electronic Data Interchange (EDI), to be used as a minimum guideline for the development of Price Sales Catalogs (transaction set 832) by Federal Supply Schedule contractors for submission of such catalogs to FSS for use in the Multi-Use File For Interagency News (MUFFIN) Gateway ordering program.

MUFFIN Gateway is an interactive, electronic bulletin board that will allow Federal agencies to review these electronic catalogs and create simplified purchase orders using model, part and descriptive information from the catalog. FSS will process these requisitions through the existing automated supply system to generate EDI purchase orders to Schedule contractors who will be able to submit EDI invoices to FSS and receive Electronic Funds Transfer (EFT) payments through the Department of Treasury's Vendor Express program.

The MUFFIN Gateway program is an addition to the on-going FSS EDI program which consists of the transmission of purchase orders (850), purchase order changes (860) and the receipt of invoices (810) and payment by EFT.

DATES: Comments concerning the GSA/FSS 832 specifications should be submitted no later than 60 days from the date of this notice.

ADDRESSES: Submit comments to the Systems, Inventory & Operations Management Center (FCS), Federal Supply Service, General Services Administration, Washington, DC 20406.

FOR FURTHER INFORMATION CONTACT: Stuart Goulden, Program Analyst, Systems, Inventory & Operations Management Center, (703) 305-7741.

SUPPLEMENTARY INFORMATION: The logical minimum segments, as defined by X12 and the Federal Supply Service's needs for a multiple award Federal Supply Schedule data, are:

ST Transaction Set Header
BCT Beginning Segment for the Price/
Sales Catalog

REF Reference Numbers
PER Administrative Communications
Contact
DTM Date/Time Reference
FOB F.O.B. Related Instructions
N1 Name
N2 Additional Name Information
N3 Address Information
N4 Geographic Location
PER Administrative Communications
Contact
LIN
Item Detail
PID Product/Item Description
MEA Measurements
PKG Marking, Packaging, Loading
PO4 Item Physical Details
TD4 Carrier Details
LDT Lead Time
FOB F.O.B. Related Instructions
CTP Pricing Information
CTT Transaction Totals
SE Transaction Set Trailer

The fundamental concept of the mapping is that there will be one contract per 832. If a firm has multiple contracts against a single schedule, then multiple 832's will need to be submitted.

Dated: May 20, 1992.

John R. Roehmer,
Director, Systems, Inventory & Operations
Management Center.

[FR Doc. 92-13117 Filed 6-3-92; 8:45 am]

BILLING CODE 6820-24-M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Agency Information Collection Under OMB Review

AGENCY: Administration for Children
and Families Office of Financial
Management.

ACTION: Notice.

Under the provisions of the Paperwork Reduction Act (44 U.S.C. chapter 35), we have submitted to the Office of Management and Budget (OMB) a request for continued use of a previously approved information collection for the Office of Financial Management (OFM) of the Administration for Children and Families.

ADDRESSES: Copies of the Information Collection request may be obtained from Steve Smith, Office of Information Systems Management, by calling (202) 401-9235.

Written comments and questions

regarding the requested approval for information collection should be sent directly to: Kristina Emanuels, OMB Desk Officer for ACF, OMB Reports Management Branch, New Executive Office Building, room 3002, 725 17th Street, NW., Washington, DC 20503, (202) 395-7316.

Information on Document

Title: Low-Income Home Energy Assistance Program (LIHEAP) Quarterly Estimates—ACF 535
OMB No.: 0970-0037

Description: Title XXVI, section 2610(a) of the Low-Income Home Energy Assistance Act of 1981 authorizes the Secretary to provide for the collection of specific data and any other information needed to carry out the provisions of this Act and, requires the Secretary to submit an annual summary of the data collection to the Congress.

Data reported on the form is used by ACF to adjust the estimated amounts obligated and to develop apportionment requests. It is also used to develop grant awards to State grantees and three Indian tribes based on an analysis of each grantee's needs. The grant awards will be used by grantees that receive over \$1 million annually for the Low-Income Energy Assistance Program. ACF will use the information as a general accounting of LIHEAP funds and to assess the utilization patterns of fuel consumption.

Annual Number of Respondents: 55

Annual Frequency: 1

Average Burden Hours Per Response: 15 min.

Total Burden Hours: 14.

Dated: May 22, 1992.

Naomi B. Marr,
Director, Office of Information Systems
Management.

[FR Doc. 92-13007 Filed 6-3-92; 8:45 am]

BILLING CODE 4130-01-M

Agency Information Collection Under OMB Review

AGENCY: Administration for Children
and Families, Family and Youth Services
Bureau (ACYF).

NOTICE: Under the provisions of the Paperwork Reduction Act (44 U.S.C. chapter 35), we have submitted to the Office of Management and Budget (OMB) a request for approval of an existing information collection entitled "State Grants for Dependent Care Planning and Development Program".

This request for OMB clearance is made by the Family and Youth Services Bureau of the Administration for Children, Youth and Families (ACYF) within the Administration for Children and Families (ACF).

ADDRESSES: Copies of the information collection request may be obtained from Steve Smith, Office of Information Systems Management, ACF, by calling (202) 401-9235.

Written comments and questions regarding the requested approval for information collection should be sent directly to: Kristina Emanuels, OMB Desk Officer for ACF, OMB Reports Management Branch, New Executive Office Building, room 3002, 725 17th Street, NW., Washington, DC 20503, (202) 395-7316.

Information on Document

Title: State Grants for Dependent Care Planning and Development Program
OMB No.: 0980-0178

Description: Subsection D of Public Law 98-558 requires States to submit an application to the Department of Health and Human Services in order to receive an allotment for dependent care planning and development activities and to submit an annual report on its activities under this program. In addition, the Law requires that both the application and the annual report include information on its intended use of these funds as well as information about prior uses of funds received under the program.

The states are required to report information on the number of children who participated in before and after school child care programs assisted under the Act; the characteristics of the children served including age levels, disabling conditions, and the income levels of families in such programs; the salary level and benefits paid to employees in such child care programs; and the number of clients served by the resource and referral systems assisted under the Act.

Annual Number of Respondents: 57

Annual Frequency: 1

Average Burden Hours Per Response: 20

Total Burden Hours: 1,140.

Dated: May 25, 1992.

Naomi B. Marr,

Director, Office of Information Systems Management.

[FR Doc. 92-13008 Filed 6-3-92; 8:45 am]

BILLING CODE 4130-01-M

Agency for Toxic Substances and Disease Registry

Workshop to Assist in Developing a Standardized Test Battery for Immune Function Disorders for Use in Environmental Health Field Studies; Meeting

The Agency for Toxic Substances and Disease Registry (ATSDR), in association with the University of Medicine and Dentistry of New Jersey—Robert Wood Johnson Medical School (a member of the Association of Occupational and Environmental Clinics), announces the following meeting.

Name: Workshop to Assist in Developing a Standardized Test Battery for Immune Function Disorders for Use in Environmental Health Field Studies.

Times and Dates: 8 a.m.–5 p.m., June 22, 1992; 8:30 a.m.–5:45 p.m., June 23, 1992.

Place: Days Hotel at Lenox, 3377 Peachtree Road, NE., Atlanta, Georgia 30326.

Status: Open to the public, limited only by the space available. The meeting room accommodates approximately 50 people.

Purpose: The purpose of this workshop is to assist ATSDR in the selection of standardized testing and evaluation methods for investigating the association between immune function disorders in humans and exposure to hazardous substances in the environment.

Matters To Be Considered: Participants will be divided into the following three workgroups:

- Workgroup 1: Hypersensitivity.
- Workgroup 2: Immune Deficiency.
- Workgroup 3: Autoimmunity.

Each workgroup will discuss three major topics:

- (1) Development of testing and evaluation methods for immediate use in environmental health studies of adults.
- (2) Development of testing and evaluation methods for immediate use in environmental health studies of children.
- (3) Identification of significant information needs in the implementation of these evaluation methods and criteria for the continuous modification and updating of the standard methods.

Contact Person for More Information: Joyce Smith, Division of Health Studies, ATSDR (MS E31), 1600 Clifton Road NE., Atlanta, Georgia 30333, telephone (404) 639-6200.

Dated: May 28, 1992.

Elvin Hilyer,

Associate Director for Policy Coordination.

[FR Doc. 92-13020 Filed 6-3-92; 8:45 am]

BILLING CODE 4160-70-M

Public Health Service

National Toxicology Program; Availability of Technical Report on Toxicology and Carcinogenesis Studies of Chlorinated Water and Chloraminated Water

The HHS' National Toxicology Program (NTP) announces the availability of the NTP Technical Report on toxicology and carcinogenesis studies of chlorinated water and chloraminated water. Chlorine and chloramine are used as disinfectants in water supplies to prevent the spread of waterborne diseases.

Toxicology and carcinogenesis studies of chlorinated water were conducted by providing water containing 0, 70, 140, or 275 ppm chlorine to groups of 70 F344/N rats or B6C3F1 mice of each sex for up to 2 years.

Under the conditions of these 2-year drinking water studies, there was no evidence of carcinogenic activity¹ of chlorinated water in male F344/N rats receiving 70, 140, or 275 ppm. There was equivocal evidence of carcinogenic activity of chlorinated water in female F344/N rats based on an increase in the incidence of mononuclear cell leukemia. There was no evidence of carcinogenic activity of chlorinated water in male or female B6C3F1 mice receiving 70, 140, or 275 ppm.

Toxicology and carcinogenesis studies of chloraminated water were conducted by providing water containing 50, 100, or 200 ppm chloramine to groups of 70 F344/N rats or B6C3F1 mice of each sex for up to 2 years.

Under the conditions of these 2-year drinking water studies, there was no evidence of carcinogenic activity of chloraminated water in male F344/N rats receiving 50, 100, or 200 ppm. There was equivocal evidence of carcinogenic activity of chloraminated water in female F344/N rats based on an increase in the incidence of mononuclear cell leukemia. There was no evidence of carcinogenic activity of chloraminated water in male or female B6C3F1 mice receiving 50, 100, or 200 ppm.

The Study Scientist for this bioassay is Dr. June Dunnick. Questions or comments about the contents of this Technical Report should be directed to

¹ The NTP uses five categories of evidence of carcinogenic activity to summarize the strength of the evidence observed in each animal study: two categories for positive results ("clear evidence" and "some evidence"), one category for uncertain findings ("equivocal evidence"), one category for no observable effect ("no evidence"), and one category for studies that cannot be evaluated because of major flaws ("inadequate study").

Dr. Dunnick at P.O. Box 12233, Research Triangle Park, NC 27709 or telephone (919) 541-4811.

Copies of Toxicology and Carcinogenesis Studies of Chlorinated Water (CAS Nos. 7782-50-5 and 7881-52-9) and Chloraminated Water (CAS No. 10599-90-3) (Deionized and Charcoal-Filtered) in F344/N Rats and B6C3F1 Mice (Drinking Water Studies) (TR 392) are available from NTP Central Data Management, NIEHS, P.O. Box 12233, MD A0-01, Research Triangle Park, NC 27709; telephone (919) 541-1371.

Dated: May 29, 1992.

Kenneth Olden,

Director, National Toxicology Program.

[FR Doc. 92-13012 Filed 6-3-92; 8:45 am]

BILLING CODE 4140-01-M

National Toxicology Program; Availability of Technical Report on Toxicology and Carcinogenesis Studies of Ethylene Thiourea

The HHS' National Toxicology Program (NTP) announces the availability of the NTP Technical Report on toxicology and carcinogenesis studies of Ethylene thiourea (ETU), used extensively in the rubber industry as an accelerator in the vulcanization of elastomers. It is also a trace contaminant and metabolic degradation product of a widely used class of ethylene bisdithiocarbamate fungicides.

Toxicology and carcinogenicity studies were conducted administering dietary concentrations of 0, 25, 83, and 250 ppm ethylene thiourea to groups of 60 F344/N rats of each sex. Dietary concentrations of 0, 100, 330, and 1,000 ppm ethylene thiourea were administered to groups of 60 B6C3F1 mice of each sex during these 2-year studies.

Under the conditions of these 2-year adult-only dietary exposures, there was clear evidence of carcinogenic activity of ethylene thiourea in male and female F344/N rats, as shown by increased incidences of thyroid follicular cell neoplasms. There was clear evidence of carcinogenic activity of ethylene thiourea in male and female B6C3F1 mice as shown by increased incidences of thyroid follicular cell neoplasms, hepatocellular neoplasms, and

adenomas of the pars distalis of the pituitary gland.

Perinatal exposure alone to ethylene thiourea had no effect on the incidences of neoplasms in rats or mice after two years. Combined perinatal and 2-year adult exposures produced marginal increases in the incidences of thyroid neoplasms, Zymbal's gland neoplasms, or mononuclear cell leukemia in some dose groups.

Nonneoplastic lesions associated with the administration of ethylene thiourea included follicular cell hyperplasia in rats and mice and follicular cell cytoplasmic vacuolation, centrilobular hepatocellular cytomegaly, and focal hyperplasia of the pars distalis of the pituitary gland in mice. Other effects associated with the administration of ethylene thiourea included decreased serum levels of T4 and/or T3 in rats and increased serum levels of TSH in rats and mice.

The Study Scientist for this bioassay is Dr. Rajendra S. Chhabra. Questions or comments about the contents of this Technical Report should be directed to Dr. Chhabra at P.O. Box 12233, Research Triangle Park, NC 27709 or telephone (919) 541-3386.

Copies of Toxicology and Carcinogenesis Studies of Ethylene Thiourea (CAS No. 96-45-7) in F344/N Rats and B6C3F1 Mice (Feed Studies) (TR 388) are available from NTP Central Data Management, NIEHS, P.O. Box 12233, MD A0-01, Research Triangle Park, NC 27709; telephone (919) 541-1371 or (919) 541-5419.

Dated: May 29, 1992.

Kenneth Olden,

Director, National Toxicology Program.

[FR Doc. 92-13013 Filed 6-3-92; 8:45 am]

BILLING CODE 4140-01-M

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

Office of Administration

[Docket No. N-92-3446]

Submission of Proposed Information Collections to OMB

AGENCY: Office of Administration, HUD.
ACTION: Notices.

SUMMARY: The proposed information collection requirements described below have been submitted to the Office of Management and Budget (OMB) for review, as required by the Paperwork Reduction Act. The Department is soliciting public comment on the subject proposals.

ADDRESS: Interested persons are invited to submit comment regarding these proposals. Comments should refer to the proposal by name and should be sent to: Jennifer Main, OMB Desk Officer, Office of Management and Budget, New Executive Office Building, Washington, DC 20503.

FOR FURTHER INFORMATION CONTACT:

Kay F. Weaver, Reports Management Officer, Department of Housing and Urban Development, 451 7th Street, Southwest, Washington, DC 20410, telephone (202) 708-0050. This is not a toll-free number. Copies of the proposed forms and other available documents submitted to OMB may be obtained from Ms. Weaver.

SUPPLEMENTARY INFORMATION: The Department has submitted the proposals for the collection of information, as described below, to OMB for review, as required by the Paperwork Reduction Act (44 U.S.C. chapter 35).

The Notices list the following information:

- (1) The title of the information collection proposal;
- (2) The office of the agency to collect the information;
- (3) The description of the need for the information and its proposed use;
- (4) The agency form number, if applicable;
- (5) What members of the public will be affected by the proposal;
- (6) How frequently information submissions will be required;
- (7) An estimate of the total number of hours needed to prepare the information submission including number of respondents, frequency of response, and hours of response;
- (8) Whether the proposal is new or an extension, rein statement, or revision of an information collection requirement; and
- (9) The names and telephone numbers of an agency official familiar with the proposal and of the OMB Desk Officer for the Department.

Authority: Section 3507 of the Paperwork Reduction Act, 44 U.S.C. 3507; section 7(d) of the Department of Housing and Urban Development Act, 42 U.S.C. 3535(d).

Dated: May 26, 1992.

John T. Murphy,

Director, Information Resources, Management Policy and Management Division.

Proposal: Request for termination of multifamily mortgage insurance.

Office: Housing.

Description of the Need for the Information and its Proposed Use: HUD-9807 will be used to inform HUD that a mortgage has been paid in full

¹ The NTP uses five categories of evidence of carcinogenic activity to summarize the evidence observed in each animal study: two categories for positive results ("clear evidence" and "some evidence"), one category for uncertain findings ("equivocal evidence"), one category for no observable effect ("no evidence"), and one category for studies that cannot be evaluated because of major flaws ("inadequate study").

or that a mortgagor and mortgagee mutually agree to terminate the contract of mortgage insurance with HUD.

Form Number: HUD-9807.
Respondents: Businesses or other for-profit.
Frequency of Submission: On occasion.

Reporting Burden:

	Number of respondents	x	Frequency of response	x	Hours per response	=	Burden hours
HUD-9807.....	480		1		.125		60

Total Estimated Burden Hours: 60.
Status: Revision.

Contact: Victor L. Vancanti, (202) 708-2022, Jennifer Main, OMB, (202) 395-6880.

Dated: May 26, 1992.

Proposal: Evaluation of the Emergency Shelter Grants Program.

Office: Policy Development and Research.

Description of the Need for the Information and its Proposed Use:

This information collection will evaluate the Emergency Shelter Grants Programs (ESGP). It will address program description, implementation, and impact status.

HUD will use the results to improve ESGP administration.

Form Number: None.

Respondents: State or local governments and non-profit Institutions.

Frequency of Submission: One-Time.

Reporting Burden:

	Number of respondents	x	Frequency of response	x	Hours per response	=	Burden hours
Information collection.....	1398		1		.692		968

Total Estimated Burden Hours: 968.
Status: New.

Contact: John Carson, HUD, (202) 708-3700, Jennifer Main, OMB, (202) 395-6880.

Dated: May 27, 1992.

[FR Doc. 92-13037 Filed 6-3-92; 8:45 am]

BILLING CODE 4210-01-M

Office of the Assistant Secretary for Community Planning and Development

[Docket No. D-92-994; FR-3276-D-01]

Redelegation of Authority for the Home Investment Partnerships (HOME) Program

AGENCY: Office of the Assistant Secretary for Community Planning and Development, HUD.

ACTION: Notice of redelegation of authority.

SUMMARY: The Assistant Secretary for Community Planning and Development is redelegating all power and authority with respect to the Home Investment Partnerships (HOME) Program to the Deputy Assistant Secretary for Grant Programs, subject to certain specified exceptions.

EFFECTIVE DATE: May 15, 1992.

FOR FURTHER INFORMATION CONTACT: Mary Kolesar, Office of Affordable Housing Programs, 451 Seventh Street,

SW., Washington, DC 20410, telephone (202) 708-2470, TDD (202) 708-2565. (These are not toll-free numbers.)

SUPPLEMENTARY INFORMATION: The Secretary delegated all power and authority with respect to the HOME Program to the Assistant Secretary for Community Planning and Development, subject to certain exceptions, on November 4, 1991, at 56 FR 56416. This delegation of authority, however, did not include the power and authority to administer the HOME Program with respect to Indian Tribes, which was delegated to the Assistant Secretary for Public and Indian Housing in a delegation of authority published on the same day at 56 FR 56417. In this redelegation, the Assistant Secretary for Community Planning and Development is redelegating to the Deputy Assistant Secretary for Grant Programs delegated authority with respect to the HOME Program, subject to additional exceptions. In another redelegation of authority published elsewhere in today's Federal Register, each Regional Administrator, Office Manager, and Director of an Office or Division of Community Planning and Development, and the Deputy of each such official, is also authorized by the Assistant Secretary for Community Planning and Development to exercise the power and authority of the Assistant Secretary with respect to the HOME Program, subject to additional exceptions.

Accordingly, the Assistant Secretary

for Community Planning and Development redelegates as follows:

Section A. Authority Redelegated

The Deputy Assistant Secretary for Grant Programs is authorized by the Assistant Secretary for Community Planning and Development to exercise the power and authority of the Assistant Secretary with respect to the HOME Program authorized by the HOME Investment Partnerships Act (42 U.S.C. 12721-17839), except the power and authority specified in section B of this notice.

Section B. Authority Excepted

There is excepted from the authority delegated under section A, the power and authority to issue or waive regulations.

Section C. No Further Redelegation

The Deputy Assistant Secretary for Grant Programs may not further redelegate the power and authority redelegated herein under section A.

Authority: HOME Investment Partnerships Act (42 U.S.C. 12721-12839); section 7(d), Department of Housing and Urban Development Act (42 U.S.C. 3535(d)).

Dated: May 15, 1992.

Randall H. Erben,

Acting Assistant Secretary for Community Planning and Development.

[FR Doc. 92-13038 Filed 6-3-92; 8:45 am]

BILLING CODE 4210-29-M

[Docket No. D-92-995; FR-3277-D-01]

Redelegation of Authority for the Home Investment Partnerships (HOME) Program

AGENCY: Office of the Assistant Secretary for Community Planning and Development, HUD.

ACTION: Notice of redelegation of authority.

SUMMARY: The Assistant Secretary for Community Planning and Development is redelegating power and authority with respect to the Home Investment Partnerships (HOME) Program to Regional Administrators, Field Office Managers, and Field Directors of Community Planning and Development Division, subject to certain specified exceptions.

EFFECTIVE DATE: May 15, 1992.

FOR FURTHER INFORMATION CONTACT: Mary Kolesar, Office of Affordable Housing Programs, 451 Seventh Street SW., Washington, DC 20410, telephone (202) 708-2470, TDD (202) 708-2565. (These are not toll-free numbers.)

SUPPLEMENTARY INFORMATION: The Secretary delegated all power and authority with respect to the HOME Program to the Assistant Secretary for Community Planning and Development, subject to certain exceptions, on November 4, 1991, at 56 FR 56416. This delegation of authority, however, did not include the power and authority to administer the HOME Program with respect to Indian Tribes, which was delegated to the Assistant Secretary for Public and Indian Housing in a delegation of authority published on the same day at 56 FR 56417. In this redelegation, the Assistant Secretary for Community Planning and Development is redelegating to specified officials of HUD Regional and Field Offices delegated authority with respect to the HOME Program, subject to additional exceptions. In another redelegation of authority published elsewhere in today's **Federal Register** the Deputy Assistant Secretary for Grant Programs is also authorized by the Assistant Secretary for Community Planning and Development to exercise the power and authority of the Assistant Secretary with respect to the HOME Program, subject to additional exceptions.

Accordingly, the Assistant Secretary for Community Planning and Development redelegates as follows:

Section A. Authority Redelegated

Each Regional Administrator, Office Manager, and Director of an Office or Division of Community Planning and Development, and the Deputy of each

such official, is authorized by the Assistant Secretary for Community Planning and Development to exercise the power and authority of the Assistant Secretary with respect to the HOME Program authorized by the HOME Investment Partnerships Act (42 U.S.C. 12721-17839), except the powers and authorities specified in Section B of this Notice.

Section B. Authority Excepted

There is excepted from the authority delegated under Section A, the powers and authorities to: (1) Determine formula allocation and reallocation amounts pursuant to section 217 (42 U.S.C. 12747); (2) establish criteria to measure the authority and administrative capacity of local governments to form consortia pursuant to section 216 (42 U.S.C. 12746); (3) revoke a jurisdiction's designation as a participating jurisdiction, pursuant to section 216 (42 U.S.C. 12746); (4) effect remedies for noncompliance pursuant to section 223 (42 U.S.C. 12753); and (5) issue or waive regulations.

Section C. No Further Redelegation

Regional Administrators, Office Managers, and Directors of an Office or Division of Community Planning and Development, and the Deputies of each such official may not redelegate the power and authority redelegated herein under section A.

Authority: HOME Investment Partnerships Act (42 U.S.C. 12721-12839); sec. 7(d), Department of Housing and Urban Development Act (42 U.S.C. 3535(d)).

Dated: May 15, 1992.

Randall H. Erben,

Acting Assistant Secretary for Community Planning and Development.

[FR Doc. 92-13039 Filed 6-3-92; 8:45 am]

BILLING CODE 4210-29-M

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[OR080-01-6310-12 (G-2-247)]

Salem District Advisory Council; Meeting

AGENCY: Bureau of Land Management, Interior.

ACTION: Meeting of the Salem District Advisory Council.

SUMMARY: Notice is hereby given in accordance with Public Law 94-579 and 43 CFR part 1780 that a meeting of the Salem District Advisory Council will be held on Thursday, June 25, 1992, beginning at 1 p.m. The meeting will be held in the Salem District Office, 1717 Fabry Rd. SE, Salem, OR.

AGENDA: The agenda for the meeting will include:

- (1) Introduction of the new members.
- (2) Appointment of a new chairperson.
- (3) Discussion of the BLM Salem District Land Use Plan and Preferred Alternative.

The meeting is open to the public. Anyone wishing to make an oral statement must notify the District Manager at the Salem District Office, 1717 Fabry Road SE, Salem, Oregon 97306 by June 19, 1992. Written comments will also be received for the council's considerations. Summary minutes will be maintained in the district office and will be available for public inspection and reproduction during regular business hours within 30 days following the meeting.

Van W. Manning,

Salem District Manager.

[FR Doc. 92-13119 Filed 6-3-92; 8:45 am]

BILLING CODE 4310-33-M

[UT-942-2112-15; UTU 69597]

Reconveyance of Certain Lands in Garfield County, Utah and Order Providing for Opening of Public Lands in Garfield County, Utah

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice.

SUMMARY: On April 19, 1989, certain public lands were conveyed to the State of Utah under IL 330, to indemnify the State for lands which could not be granted at statehood. Through an out-of-court settlement some of the lands granted under IL 330 were quit claimed back to the United States. This order will open the reconveyed lands to the operation of the public land laws and the mining laws.

EFFECTIVE DATE: July 6, 1992.

FOR FURTHER INFORMATION CONTACT: Randy Massey, BLM Utah State Office, P.O. Box 45155, Salt Lake City, Utah 84145-0155, (801) 539-4119.

SUPPLEMENTARY INFORMATION: Notice is hereby given that the following lands were reconveyed to the United States by quit claim deed from the State of Utah. These lands were conveyed to the State in IL 330, dated April 19, 1989. Through an out of court settlement, it was agreed that the State of Utah would deed certain lands back to the United States. The following lands were quite claimed to the United States on February 27, 1992:

Salt Lake Meridian
T. 36 S., R. 5 E.,

Sec. 34, S½SE¼

Sec. 35, S½N½SW¼, S½SW¼, SE¼.

T. 37 S., R. 5 E.,

Sec. 1, lots 1-4, S½N½, S½;

Sec. 3, lots 1-4, S½N½, S½

Sec. 9, all;

Sec. 10, all;

Sec. 11, all;

Sec. 12, all;

Sec. 13, NE¼, N½NW¼, SW¼NW¼, S½;

Sec. 14, all;

Sec. 15, all.

The areas described aggregate approximately 6,074.56 acres in Garfield County.

At 9 a.m. on July 6, 1992, the lands will be opened to the operation of the public land laws generally, subject to valid existing rights and requirements of applicable law. All valid applications received at or prior to 9 a.m. on July 6, 1992, shall be considered in the order of filing.

At 9 a.m. on July 6, 1992, the lands will be opened to location and entry under the United States mining laws, subject to valid existing rights and requirements of applicable law. Appropriation of any of the lands described in this notice under the general mining laws prior to the date and time of opening is authorized. Any such attempted appropriation, including attempted adverse possession under 30 U.S.C. 38 (1988), shall vest no rights against the attempted adverse possession under 30 U.S.C. 38 (1988), shall vest no rights against the United States. Acts required to establish a location and to initiate a right of possession are governed by State law where not in conflict with Federal law. The Bureau of Land Management will not intervene in disputes between rival locators over possessory rights since Congress has provided for such determinations in local court.

Ted D. Stephenson,

Deputy State Director, Operations.

[FR Doc. 92-13018 Filed 6-3-92; 8:45 am]

BILLING CODE 4310-DQ-M

[CA-010-4212-13, CACA 30078]

Realty Action; Exchange of Public Land in Yuba and Nevada Counties, CA

AGENCY: Bureau of Land Management, Department of the Interior.

SUMMARY: The following described public land (surface and mineral estate) is being considered for exchange under Section 206 of the Federal Land Policy and Management Act of 1976 (43 U.S.C. 1716):

Selected Public Land

Yuba County

T.17N., R.7E., M.D.M.

Sec. 2: Lot 2, SW¼NE¼, NW¼SE¼

T.18N., R.7E., M.D.M.

Sec. 28: Lots 1 and 2

Nevada County

T.16N., R.9E., M.D.M.

Sec. 8: Lot 2

T.17N., R.10E., M.D.M.

Sec. 20: SE¼SE¼

Sec. 28: Lots 5, 6 and 7

Aggregating 364.87-Acres, more or less

The selected public land described above is hereby segregated from settlement, location and entry under the public land laws and from the mining laws for a period of two years from the date of publication of this notice in the Federal Register.

The above land is being considered for possible, transfer to a nonprofit conservation organization. In exchange, the public would receive private land located on either the North Fork or South Fork of the American River or the Merced River, or marshlands and waterfowl habitat located in the California Central Valley. This proposal is considered to be in the public interest and is consistent with current land use plans.

SUPPLEMENTARY INFORMATION: The above described Federal land would be transferred subject to a reservation to the United States for a right-of-way for ditches and canals constructed under the authority of the Act of August 20, 1890 (43 U.S.C. 945); also right-of-way of record would be identified as prior existing rights.

All necessary clearances including clearances for archaeology, rare plants and animals would be completed prior to any conveyance of title by the U.S.

FOR ADDITIONAL INFORMATION: Contact Mike Kelley, (916) 985-4474 or at the address listed below.

ADDRESS: For a period of 45 days from publication of this notice in the Federal Register, interested parties may submit comments to the District Manager, c/o the Area Manager, Folsom Resource Area, 63 Natoma Street, Folsom, CA 95630.

Dated: May 27, 1992.

D.K. Swickard,

Area Manager.

[FR Doc. 92-13116 Filed 6-3-92; 8:45 am]

BILLING CODE 4310-40-M

[UT-942-02-5700-11; UTU-67372]

Realty Action, Noncompetitive Lease of Public Land in Grand County, UT

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice of realty action, UTU-67372, noncompetitive lease of public land in Grand County, Utah.

SUMMARY: Notice is given that the following described parcel of public land has been examined, and through the development of local land-use planning decisions, based upon public input, resource considerations, regulations, and Bureau policies, the parcel has been found suitable for lease pursuant to section 302 of the Federal Land Policy and Management Act of 1976 (FLPMA) (90 Stat. 2762; 43 U.S.C. 1732) using noncompetitive (direct) lease procedures (43 CFR 2920.5-4(b)).

Salt Lake Meridian, Utah

T. 24 S., R. 23 E., SLM

Section 27, S½SE¼NE¼SW¼NE¼, SW¼SW¼NW¼SE¼NE¼, NE¼SE¼SW¼NE¼, W½NW¼SW¼SE¼NE¼, N½SE¼SE¼SW¼NE¼, NW¼SW¼SW¼SE¼NE¼, N½SW¼SE¼SE¼SW¼NE¼, N½SW¼SW¼SW¼SE¼NE¼.

The described parcel aggregates approximately 8.4 acres.

The lands are presently used by Canyonlands Field Institute (CFI), a non-profit educational organization, for an educational field camp under a special recreation permit. Students camp in a remote location and are provided with meals, classroom and bathroom facilities. The BLM proposes to issue a 5-year renewable lease to CFI to convert to a more appropriate authorization for the existing facility. The proposed lease would not authorize the construction of any permanent structures. The camp would essentially be removable with the help of a backhoe and would be reclaimed at the termination of the authorization.

The parcel is being offered as a noncompetitive (direct) lease to CFI in accordance with 43 CFR 2920.5-4(b) at no less than fair market rental. The proposal is a change of authorization to an organization that has shown good stewardship of the land. The lease would be subject to all valid existing rights.

COMMENTS: For a period of forty-five (45) days from the date of publication of this notice in the Federal Register, interested parties may submit comments to the Moab District Manager, Bureau of Land Management, P.O. Box 970, Moab, Utah 84532. Objections will be reviewed by the Utah State Director who may

sustain, vacate, or modify this realty action. In the absence of any objections, this realty action will become the final determination of the Department of Interior.

SUPPLEMENTARY INFORMATION: For further information, contact Mary von Koch, Realty Specialist, Grand Resource Area Office, 885 So. Sand Flats Road, Moab, Utah 84532, (801) 259-8193, or from Brad Groesbeck, District Realty Specialist, Moab District Office, 82 East Dogwood, P.O. Box 970, Moab, Utah 84532, (801) 259-6111.

Dated: May 28, 1992.

Kenneth V. Rhea,
Acting District Manager.

[FR Doc. 92-13049 Filed 6-3-92; 8:45 am]

BILLING CODE 4310-DQ-M

[UT-060-02-4212-14; UTU-57115 through UTU-57119]

Realty Action, Competitive and Noncompetitive Sale of Public Land in Grand County, UT

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice of Realty Action, UTU-57115 through UTU-57119, Competitive and Noncompetitive Sale of Public Land in Grand County, Utah.

SUMMARY: Notice is given that the following described parcels of public land have been examined, and through the development of local land-use planning decisions, based upon public input, resource considerations, regulations, and Bureau policies, the parcels have been found suitable for disposal by sale pursuant to section 203 of the Federal Land Policy and Management Act of 1976 (FLPMA) (90 Stat. 2750; 43 U.S.C. 1713) using competitive and noncompetitive sale procedures (43 CFR 2711.3-1 and 43 CFR 2711.3-3).

The parcels are difficult and uneconomic to manage as public lands, are not needed for any resource programs, and are not suitable for management by the Bureau of any other Federal department or agency.

Parcels to Be Offered for Competitive Sale

Serial Number, legal description, acreage, and appraised fair market value
UTU-57115 T. 21 S., R. 20 E., SLM, Utah.
Section 20, SW 1/4 SW 1/4 (40 acres)
\$6,000.00

UTU-57116 T. 21 S., R. 20 E., SLM, Utah.
Section 29, Lots 3, 4, 5 (80.34 acres)
\$15,300.00

UTU-57117 T. 21 S., R. 20 E., SLM, Utah.
Section 29, Lots 1, 2 (29.95 acres)
\$24,000.00

Parcels UTU-57115-117 are public lands isolated by private land and Interstate Highway 70. They have public access from Grand County roads.

Parcels to Be Offered for Noncompetitive Direct Sale

The following two parcels will be offered for sale to Lester Rogers, the adjacent landowner. The lands are isolated by Mr. Rogers' private lands and Interstate 70. The only physical access to the lands is from the private lands. Legal access is available through public lands east of the parcels. The fair market value for these parcels will be based on sales data collected from the competitive sale of parcels UTU-57115, UTU-57116, and UTU-57117.

UTU-57118 T. 21 S., R. 20 E., SLM, Utah.
Section 28, Lot 2 (19.32 acres)

UTU-57119 T. 21 S., R. 20 E., SLM, Utah.
Section 28, Lot 1 (41.21 acres)

The parcels will not be offered for sale until at least sixty (60) days after publication of this notice in the *Federal Register*. The sale will be at no less than the appraised fair market value.

Publication of this notice will serve as the 2-year notification to the grazing permittees of a reduction of grazing privilege in grazing authorization numbers 6318 (Crescent Junction Allotment) and 6342 (Crescent Canyon Allotment).

Publication of this notice in the *Federal Register* segregates the public land from the operation of the public land laws and the mining laws. The segregative effect will end upon issuance of a patent, or two hundred seventy (270) days from the date of publication, whichever occurs first.

The terms and conditions applicable to the sale are

1. All minerals, including oil and gas, shall be reserved to the United States, together with the right to prospect for, mine, and remove the minerals.
2. A right-of-way will be reserved for ditches and canals constructed by the authority of the United States (Act of August 30, 1890, 26 Stat. 391; 43 U.S.C. 945).
3. The sale of the parcels will be subject to all valid existing rights, reservations, and privileges of record including, but not limited to the following:

Parcel UTU-57115

a. A right-of-way (RCW) for Grand County Road #175 acquired through relinquishment by the Federal Highway Administration (FHWA).

b. Right-of-way UTUO-146642 for a 3" buried culinary water pipeline within the road ROW authorized under the Act

of February 15, 1901 (31 Stat. 790; 43 U.S.C. 959).

Parcel UTU-57116

a. A 100'-wide right-of-way for County Road #144 acquired through relinquishment by the FHWA.

b. Right-of-way UTU-39051 for a buried powerline within the road ROW authorized under Title V of the Act of October 21, 1976 (90 Stat. 2776; 43 U.S.C. 1761).

c. Right-of-way UTSLO-42141 for a 10'-wide ROW for an aerial telephone line authorized under Title V of the Act of October 21, 1976 (90 Stat. 2776; 43 U.S.C. 1761).

Parcel UTU-57117

a. A 100'-wide right-of-way for County Road #144 acquired through relinquishment by the FHWA.

b. Right-of-way UTU-39051 for a buried powerline within the road ROW authorized under Title V of the Act of October 21, 1976 (90 Stat. 2776; 43 U.S.C. 1761).

c. Right-of-way UTSLO-42141 for a 10'-wide ROW for an aerial telephone line authorized under Title V of the Act of October 21, 1976 (90 Stat. 2776; 43 U.S.C. 1761).

Parcel UTU-57119

a. Right-of-way UTSLO-42141 for a 10'-wide ROW for an aerial telephone line authorized under Title V of the Act of October 21, 1976 (90 Stat. 2776; 43 U.S.C. 1761).

Competitive Sale Procedures

Sealed bids would be accepted at the Grand Resource Area Office, 885 S. Sandflats Road, Moab, Utah 84532 from 7:45 a.m., MDT, on August 3, 1992 until 3 p.m., MDT, on August 14, 1992. Bid envelopes must be marked on the right front corner with "Bid for Public Sale, Parcel # UTU _____, and sale date (August 14, 1992)". Bids must be at no less than the appraised fair market value specified in this notice. Each bid must be in a sealed envelope accompanied by a certified check, postal money order, bank draft or cashier's check made payable to the Department of the Interior, BLM, for no less than twenty (20) percent of the amount bid. A statement as to the amount of the full bid shall be enclosed. The sealed bids will be opened publicly after 3 p.m. on August 14, 1992 at the Grand Resource Area Office. The highest qualifying sealed bid for each parcel will be declared by the authorized officer. Oral bids, in \$100 increments, will be invited to determine the apparent high bidder. The person declared to have entered the

highest qualifying bid shall submit payment by cash, personal check, bank draft, money order, or any combination for not less than one-fifth of the amount of the bid immediately following the close of the sale. The successful bidder shall submit the remainder of the full bid price prior to the expiration of 180 days from the date of the sale. If a parcel is not sold on the sale date, it will remain for sale over the counter until sold or withdrawn from the market.

Noncompetitive Sale Procedures

Following the competitive sale, the fair market value of parcels UTU-57118 and UTU-57119 will be determined. The parcels would be offered for direct sale to Lester Rogers at no less than the appraised fair market value on September 14, 1992. In the event that the direct sale does not go through, the unsold parcel(s) would be available for sale over-the-counter starting at 7:45 a.m. on October 5, 1992 and would remain for sale until sold or withdrawn from the market. If both parcels are not sold by direct sale, either both parcels must be sold together or the western parcel must be sold first to prevent the isolation of parcel UTU-57118.

Bidder Qualifications

Bidders must be U.S. citizens, 18 years of age or over; a State or State instrumentality authorized to hold property; a corporation authorized to hold property; or a corporation authorized to own real estate in the State of Utah.

Bid Standards

The BLM reserves the right to accept or reject any and all offers or withdraw the land from sale if, in the opinion of the Authorized Officer, consummation of the sale would not be fully consistent with section 203(g) of FLPMA or other applicable laws.

COMMENTS: By July 20, 1992, interested parties may submit comments to the Moab District Manager, Bureau of Land Management, P.O. Box 970, Moab, Utah 84532. Objections will be reviewed by the Utah State Director who may sustain, vacate, or modify this realty action. In the absence of any objections, this realty action will become the final determination of the Department of the Interior.

SUPPLEMENTARY INFORMATION:

Additional information, including a brochure describing the parcels, may be obtained from Mary von Koch, Area Realty Specialist, Grand Resource Area, 885 So. Sanflats Road, Moab, Utah 84532, (801) 259-8193, or from Brad Croesbeck, District Realty Specialist,

Moab District Office, 82 East Dogwood Drive, P.O. Box 970 Moab, Utah 84532, (801) 259-6111.

Dated: May 27, 1992.

Kenneth V. Rhea,

Acting District Manager.

[FR Doc. 92-13050 Filed 6-3-92; 8:45 am]

BILLING CODE 4310-DQ-M

[NM-030-02-4351-08]

Intent To Prepare Resource Management Plan Amendment; Caballo Resource Area, NM

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice of intent and invitation to participate in an amendment to the White Sands Resource Management Plan.

SUMMARY: The Bureau of Land Management (BLM), Las Cruces District, New Mexico, is initiating the preparation of a Resource Management Plan (RMP) Amendment to consider the reintroduction and management of desert bighorn sheep in the Caballo Mountains in Sierra County, near Truth or Consequences, New Mexico. The RMP Amendment will include an Environmental Assessment (EA).

The public is invited to participate in the planning process. Two public scoping meetings will be held to obtain public input on concerns with the RMP Amendment for bighorn sheep reintroduction. The meetings will be held at the following times and locations:

Date/Time and Location

June 23, 1992, 7 p.m.—Civic Center, 400 West 4th St., Truth or Consequences, New Mexico.

June 25, 1992, 7 p.m.—BLM District Office, 1800 Marquess St., Las Cruces, New Mexico.

DATES: Comments relating to the amendment will be accepted until July 6, 1992.

ADDRESSES: Comments should be sent to: Tim Murphy, Area Manager, BLM, 1800 Marquess St., Las Cruces, New Mexico 88005.

FOR FURTHER INFORMATION CONTACT: Tim Sanders, Supervisory Natural Resource Specialist of Mike Howard, Wildlife Biologist, BLM, Las Cruces District, Caballo Resource Area, 505-525-8228.

SUPPLEMENTARY INFORMATION: The BLM Las Cruces District, in cooperation with the New Mexico Department of Game and Fish, proposes to reintroduce desert bighorn sheep to approximately 30,000 acres of historic range in the Caballo

Mountains of south-central New Mexico. Because desert bighorn sheep are listed as endangered by the State of New Mexico, there is an urgent need to provide for the perpetuation of this subspecies. The White Sands Resource Management Plan (WSRMP), which guides management of the Caballo Mountains, prescribes management for desert mule deer. Reintroduction of bighorn sheep is not addressed in the WSRMP. To consider this new management direction, an RMP Amendment/EA will be completed.

The RMP Amendment will address the proposed action as well as alternatives to that proposal. Specifics of the proposed action are as follows:

1. Provide for the immediate (October 1992) reintroduction of approximately 35 desert bighorn sheep, and subsequent management of a viable population (100 animals) as a primary use of the Caballo Mountains.

2. Develop a Habitat Management Plan following the reintroduction to address management of bighorn sheep and other wildlife species and habitats (including endangered or sensitive plants and animals).

3. Close the Caballo Mountains to off-road vehicles (43 CFR 8341.1(c)) to minimize human disturbance (presence) in the area.

a. The closure would require mining claimants to submit a mining plan of operations for any action, except casual use, within the closed area. Vehicular access for casual use would require authorization. BLM would work with miners, through the plan of operations, to mitigate impacts to bighorn sheep and other sensitive resources in the area (43 CFR 3809.1-4(5)).

b. Provision for specific access needs, such as grazing, mining, and other uses could be authorized by BLM (43 CFR 8340.0-5(h)).

c. The road to the Caballo Mountain Communication Site would remain open to the public.

4. Limit the class of livestock authorized to graze on BLM administered public land to cattle and horses east of the Rio Grande to the White Sands Missile Range boundary, 9 miles west of the Caballo Mountains, and elsewhere within 9 miles of any occupied or likely to be occupied bighorn sheep range in Sierra County. Domestic sheep and goats would not be permitted to graze on public land in these areas. This would be to prevent transmission of disease to bighorn sheep in the Caballo Mountains, the San Andres Mountains, and other areas.

5. The proposed action does not call for the designation of Areas of Critical

Environmental Concern (ACEC), withdrawal of lands from minerals or other public land laws, or Federal acquisition of private or State trust lands, or limitation of existing livestock operations other than as described in item 4. The RMP amendment/EA will be prepared by the wildlife habitat management staff and minerals, lands, recreation, and grazing specialists. Additional support will be provided by other specialists as needed. The RMP Amendment/EA will be developed in coordination with the New Mexico Department of Game and Fish. Public participation activities during the planning process will include consultation with affected users, meetings with interested groups and individuals, mail outs, media notices, Federal Register notices, public meetings, and distribution of the RMP Amendment/EA for comments. Complete records of the planning process will be available for public review at the BLM District Office.

Dated: May 29, 1992.

Larry L. Woodard,
State Director.

[FR Doc. 92-13019 Filed 6-3-92; 8:45 am]

BILLING CODE 4310-FB-M

Office of Surface Mining Reclamation and Enforcement

Information Collection Submitted to the Office of Management and Budget for Review Under the Paperwork Reduction Act

The proposal for the collection of information listed below has been submitted to the Office of Management and Budget for approval under the provisions of the Paperwork Reduction Act (44 U.S.C. chapter 35). Copies of the proposed collection of information and related form and explanatory material may be obtained by contacting the Bureau's clearance officer at the phone number listed below. Comments and suggestions on the requirements should be made directly to the bureau clearance officer and to the Office of Management and Budget, Paperwork Reduction Project (1029-0080), Washington, DC 20503, telephone 202-395-7340.

Title: 30 CFR part 882—Reclamation on Private Lands.

OMB Number: 1029-0057.

Abstract: Section 408 of the Surface Mining Control and Reclamation Act of 1977, Public Law 95-87, provides that under certain circumstances liens may be levied on private property that has been reclaimed. Part 882 establishes procedures for recovery of the cost of

reclamation activities conducted on privately owned lands and is intended to ensure that land owners who acquired the land after a specified date or who benefitted from the mining operation will not realize the windfall from the reclamation.

Bureau Form Number: Not applicable.

Frequency: As required.

Descriptions of Respondents: States and Indian tribes.

Estimated Completion Time: One hour.

Annual Responses: One.

Annual Reporting Burden: One.

Bureau Clearance Officer: Andrew DeVito 202-343-5150.

Dated: April 24, 1992.

John Mosesso,

Chief, Division of Technical Services.

[FR Doc. 92-13115 Filed 6-3-92; 8:45 am]

BILLING CODE 4310-05-M

INTERSTATE COMMERCE COMMISSION

Motor Passenger Carrier or Water Carrier Finance Applications Under 49 U.S.C. 11343-11344

The following applications seek approval to consolidate, purchase, merge, lease operating rights and properties of, or acquire control of motor passenger carriers or water carriers pursuant to 49 U.S.C. 11343-11344. The applications are governed by 49 CFR part 1182, as revised in Pur., Merger & Cont.-Motor Passenger & Water Carriers, 5 I.C.C.2d 786 (1989). The findings for these applications are set forth at 49 CFR 1182.18. Persons wishing to oppose an application must follow the rules under 49 CFR 1182, subpart B. If no one timely opposes the application, this publication automatically will become the final action of the Commission.

Sidney L. Strickland, Jr.,

Secretary.

MC-F-20086, filed May 27, 1992.

VanCom, Inc., John G. Van Der Aa, and Terry L. Van Der Aa—Continuance in control—American Transit Corp., d/b/a Huskie Line; American Transit Corp., d/b/a/ Valley Coach; VanCom-Illinois, Inc.; Royal American Charter Lines, Inc.; and VanCom-Connecticut, Inc. Applicant's representatives: Arnold L. Burke, 180 N. LaSalle Street, Suite 2025, Chicago, IL 60601. VanCom, Inc. (VanCom) (MC-163845), a passenger carrier controlled by John G. and Terry L. Van Der Aa, non-carrier individuals, seek approval of VanCom's continuance in control of American Transit Corp., d/b/a Huskie Line, (Huskie) (MC-168387); American Transit Corp., d/b/a/ Valley

Coach (Valley) (MC-205760); VanCom-Illinois, Inc., (VanCom-Ill.) (MC-167816); Royal American Charter Lines, Inc., (Royal) (MC-165919); all common carriers of passengers, and VanCom-Connecticut, Inc., (VanCom-Conn.) (MC-219430), a new carrier seeking its initial common carrier authority to transport passengers, in charter and special operations, between points in the United States (except AK and HI). VanCom also controls Indian Bus Service, Inc., (Indiana) (MC-141600), and Van Der Aa Bus Lines, Inc., (Van) (MC-190458). The control by VanCom of Indiana and Van was previously approved in MC-F-14359. A request to merger the authority held by VanCom-Ill. into that of Van will be filed in a separate application. VanCom will control seven carriers upon the issuance of authority to Royal.

[FR Doc. 92-13092 Filed 6-3-92; 8:45 am]

BILLING CODE 7035-01-M

[Finance Docket No. 32073]

The Alabama Great Southern Railroad Co.—Trackage Rights Exemption—Burlington Northern Railroad Co.

Burlington Northern Railroad Company (BN) has agreed to grant overhead trackage rights to The Alabama Great Southern Railroad Company (AGS) over approximately 2 miles of its line, at York, AL, between the junction of the BN line with AGS's line at milepost 731.47 and milepost 729.2 at a lumber facility operated by ATN Lumber, for the purpose of allowing AGS to provide direct service to and from the lumber facility. The trackage rights will become effective on or after June 15, 1992.

This notice is filed under 49 CFR 1180.2(d)(7). Petitions to revoke the exemption under 49 U.S.C. 10505(d) may be filed at any time. The filing of a petition to revoke will not stay the transaction. Pleadings must be filed with the Commission and served on: James L. Howe III, Northern Southern Railway Company, Three Commercial Place, Norfolk, VA 23510-2191.

As a condition to the use of this exemption, any employees affected by the trackage rights will be protected pursuant to Norfolk and Western Ry. Co.—Trackage Rights—BN, 354 I.C.C. 605 (1978), as modified in Mendocino Coast Ry., Inc.—Lease and Operate, 360 I.C.C. 653 (1980), and as clarified in Wilmington Term. RR, Inc.—Pur & Leases—CSX Transp., Inc., 6 I.C.C.2d 799 (1990), aff'd sub nom. Railway Labor Executives' Ass'n v. ICC, 930 F.2d 511 (6th Cir. 1991).

Dated: May 29, 1992.

By the Commission, David M. Konschnik,
Director, Office of Proceedings.

Sidney L. Strickland, Jr.,

Secretary.

[FR Doc. 92-13091 Filed 6-3-92; 8:45 am]

BILLING CODE 7035-01-M

[Finance Docket No. 32069]

**McCloud Railway Co.—Acquisition and
Operation Exemption—McCloud River
Railroad Co.**

McCloud Railway Company (MRC), a wholly owned subsidiary of 4 Rails, Inc. (4 Rails),¹ both non-carriers, filed a notice of exemption to: (1) Acquire and operate the railroad assets of McCloud River Railroad Company (McCloud River);² and (2) to operate over 34.1 miles of Burlington Northern Railroad Company (BN) track between milepost BH-0 at Lookout and milepost BH-34.1 at Hambone in Siskiyou and Modoc Counties, CA (Lookout Branch). McCloud River owns and operates 96.8 miles of track in Siskiyou and Shasta Counties, CA, between: (1) Milepost 0 at McCloud and milepost M-15.8 at Mt. Shasta (Mt. Shasta Line); (2) milepost 0 at McCloud and milepost 31 at Hambone (Hambone Line); (3) milepost 18 near Bartle and milepost B-61 at Burney (Burney Line); and (4) milepost B-58 near Burney and milepost S-7 also near Burney (Sierra Branch). The proposed transaction was to have been consummated on or about May 18, 1992.

Any comments must be filed with the Commission and served on: Jeff E. Forbis, 511 Freeman Lane, Mt. Shasta, CA 96067.

This notice is filed under 49 CFR 1150.31. If the notice contains false or misleading information, the exemption is void *ab initio*. Petitions to revoke the exemption under 49 U.S.C. 10505(d) may be filed at any time. The filing of a petition to revoke will not automatically stay the transaction.

Decided: May 29, 1992.

By the Commission, David M. Konschnik,
Director, Office of Proceedings.

Sidney L. Strickland, Jr.,

Secretary.

[FR Doc. 92-13090 Filed 6-3-92; 8:45 am]

BILLING CODE 7035-01-M

¹ 4 Rails is wholly owned by Jeff E. Forbis and W. Verline Forbis, husband and wife.

² McCloud River is a class III wholly owned railroad subsidiary of Irel Rail Corporation, which is a wholly owned subsidiary of Irel Corporation.

DEPARTMENT OF JUSTICE

Lodging of Consent Decree

In accordance with the policy of the Department of Justice, 28 CFR 50.7, notice is hereby given that a proposed Consent Decree in *United States v. Chevron U.S.A., Inc.*, CV 88-7836 RSWL, was lodged with the United States District Court for the Central District of California on May 18, 1992. This action was brought by the United States pursuant to section 309 of the Clean Water Act, 33 U.S.C. 1319.

Under the proposed Consent Decree, Chevron U.S.A., Inc., agrees to pay \$1,500,000 to the United States to resolve the civil claims of the United States against Chevron for repeated violations of Chevron's National Pollutant Discharge Elimination System permit issued for its oil platform known as Platform Grace located in the Santa Barbara Channel. The proposed Decree permanently enjoins Chevron from further violations of its permit or the Clean Water Act.

The Department of Justice will receive comments relating to the proposed Consent Decree for a period of 30 days from the date of this publication. Comments should be addressed to the Acting Assistant Attorney General of the Environment and Natural Resources Division, Department of Justice, 10th and Pennsylvania Ave., Washington, DC 20530. All comments should refer to *United States v. Chevron U.S.A., Inc.*, D.J. Ref. 90-5-1-1-3178.

The proposed Consent Decree may be examined at the office of the United States Attorney, 312 North Spring Street, Los Angeles, California 90012. A copy of the proposed Consent Decree may also be examined at the Environmental Enforcement Section, Document Center, 601 Pennsylvania Avenue Building, NW., Washington, DC 20004 (202-347-2072).

A copy of the proposed Consent Decree may be obtained in person or by mail from the Environmental Enforcement Section Document Center, 601 Pennsylvania Avenue NW., Box 1097, Washington, DC 20004. Any request for a copy of the proposed Consent Decree should be accompanied by a check in the amount of \$2.50 for copying costs (\$0.25 per page) payable to "Consent Decree Library".

Barry M. Hartman,

Acting Assistant Attorney General
Environment and Natural Resources Division.

[FR Doc. 92-12989 Filed 6-3-92; 8:45 am]

BILLING CODE 4410-01-M

**Lodging of Consent Decree Pursuant
to the Clean Air Act**

In accordance with Departmental policy, 28 CFR 50.7, notice is hereby given that a proposed partial consent decree in *United States v. City of Jamestown, et. al.* (D.N.D.), (Civil Action number A-3-92-76) was lodged on May 13, 1992 with the United States District Court for the District of North Dakota. The decree requires defendant City of Jamestown, if it conducts demolition or renovation activities in a facility where asbestos containing material ("ACM") is present, to hire an asbestos consultant to determine whether such activities will: (a) Fracture, break up, dislodge or disturb the ACM, (b) prevent access to the ACM for later removal, or (c) expose any worker to airborne ACM fibers. If the answer to any of the above questions is affirmative, the City is required to remove the ACM in accordance with the National Emission Standard for Hazardous Air Pollutants (NESHAP) promulgated for asbestos pursuant to sections 112 and 114 of the Clean Air Act, 42 U.S.C. 7412 and 7414, and to employ an asbestos consultant to review and approve the asbestos abatement plans, and monitor all asbestos abatement measures during removal and disposal of ACM. The decree also requires future compliance with the asbestos NESHAP regulations and provides for stipulated penalties for future violations.

The Department of Justice will receive, for a period of thirty (30) days from the date of this publication, comments relating to the proposed consent decree. Comments should be addressed to the Assistant Attorney General for the Environment and Natural Resources Division, Department of Justice, Washington, DC 20530, and should refer to *United States v. City of Jamestown*, DOJ reference #90-5-2-1-1427.

The proposed consent decree may be examined at the Office of the United States Attorney for the District of North Dakota, 219 Federal Building, 655 First Avenue North, Fargo, North Dakota, 58102, and at the Environmental Enforcement Section Document Center, 601 Pennsylvania Avenue NW., Box 1097, Washington, DC 20004, (202) 347-2072. A copy of the proposed consent decree may be obtained in person or by mail from the Document Center. In requesting a copy, please enclose a check in the amount of \$3.75 (25 cents

per page reproduction costs), payable to "Consent Decree Library".

John C. Cruden,

Chief, Environmental Enforcement Section,
Environment and Natural Resources Division.
[FR Doc. 92-12988 Filed 6-3-92; 8:45 am]

BILLING CODE 4410-01-M

Lodging of Consent Decree; United States v. Union Pacific Railroad Company

In accordance with Departmental policy, 28 CFR 50.7, and pursuant to section 122(d)(2)(B) of the Comprehensive Environmental Response, Compensation, and Liability Act of 1980, as amended ("CERCLA"), 42 U.S.C. 9622(d)(2)(B), notice is hereby given that a Consent Decree in *United States v. Union Pacific Railroad Company*, Civil Action No. 92 0210 E-EJL was lodged with the United States District Court for the District of Idaho on May 22, 1992. This action was brought under sections 106 and 107 of CERCLA, 42 U.S.C. 9606 and 9607. The Consent Decree provides the defendant Union Pacific Railroad Company will clean up the Union Pacific Railroad Sludge Pit Superfund Site as required by the Record of Decision issued by the U.S. Environmental Protection Agency on September 10, 1991, pay \$167,333.07, the past response costs incurred by the federal government, and pay all future response and oversight costs incurred by the federal government.

For thirty (30) days from the date of publication of this notice, the Department of Justice will receive written comments relating to the Consent Decree from persons who are not parties to the action. Comments should be addressed to the Assistant Attorney General, Environment and Natural Resources Division, Department of Justice, Washington, DC 20530 and should refer to *United States v. Union Pacific Railroad Company*, D.O.J. Ref. No. 90-11-2-751.

The Consent Decree may be examined at the Offices of the United States Attorney, District of Idaho, room 327, Federal Building, 550 West Fort Street, Boise, Idaho 83724 and at the Region X Office of the United States Environmental Protection Agency, 1200 Sixth Avenue, Seattle, Washington, 99101.

A copy of the Consent Decree also may be examined at the Environmental Enforcement Section Document Center, 601 Pennsylvania Avenue NW., Box 1097, Washington, DC 20004. Telephone number (202) 347-2072. A copy of the Consent Decree may be obtained in person or by mail from the

Environmental Enforcement Section Document Center. The proposed Consent Decree package consists of a 77 page Consent Decree and 194 pages of appendices. You may request a copy of the Consent Decree with or without the appendices. Please specify in the request whether or not the appendices are requested. A request for a copy of the proposed Consent Decree with appendices should be accompanied by a check for in the amount of \$67.75 (25 cents per page reproduction charge) made payable to "Consent Decree Library." A request for a copy of the proposed Consent Decree without appendices should be accompanied by a check in the amount of \$19.25.

Roger Clegg,

Acting Assistant Attorney General,
Environment and Natural Resources Division.
[FR Doc. 92-12987 Filed 6-3-92; 8:45 am]

BILLING CODE 4410-01-M

Antitrust Division

Notice Pursuant to the National Cooperative Research Act of 1984—Network Management Forum

Notice is hereby given that, pursuant to section 6(a) of the National Cooperative Research Act of 1984, 15 U.S.C. 4301 *et seq.* ("the Act"), the Network Management Forum, formerly known as OSI/Network Management Forum, ("the Forum") on April 27, 1992, filed an additional written notification simultaneously with the Attorney General and the Federal Trade Commission disclosing additions to its membership. The additional notification was filed for the purpose of extending the protections of Section 4 of the Act, limiting the recovery of antitrust plaintiffs to actual damages under specified circumstances.

On October 21, 1988, the Forum filed its original notification pursuant to section 6(a) of the Act. The Department of Justice published a notice in the *Federal Register* pursuant to section 6(b) of the Act on December 8, 1988 (53 FR 49615). On December 23, 1988, March 23, 1989, July 3, 1989, September 28, 1989, November 22, 1989, January 29, 1990, March 20, 1990, May 7, 1990, July 20, 1990, February 27, 1991, April 17, 1991, and June 28, 1991, the Forum filed additional written notifications pursuant to section 6(a) of the Act. The Department published notices in the *Federal Register* pursuant to section 6(b) on January 26, 1989 (54 FR 3870), April 25, 1989 (54 FR 17834), August 4, 1989 (54 FR 32141), October 26, 1989 (54 FR 43631), January 10, 1990 (55 FR 926), February 28, 1990 (55 FR 7046), April 23,

1990 (55 FR 15295), May 24, 1990 (55 FR 21449), August 20, 1990 (55 FR 33967), April 3, 1991 (56 FR 13655), May 23, 1991 (56 FR 23723), and August 1, 1991 (56 FR 36847), respectively.

The identities of the additional parties to the venture are given below:

Affiliate Member: JP Morgan Co., New York, NY

Corporate Member: Mitsubishi Electric Corp., Kamakura, Japan

Joseph H. Widmar,
Director of Operations, Antitrust Division.
[FR Doc. 92-13114 Filed 6-3-92; 8:45 am]

BILLING CODE 4410-01-M

National Institute of Corrections Advisory Board Meeting

Time and Date: 8 a.m., Tuesday, June 30, 1992.

Place: Raintree Plaza Hotel and Conference Center, 1900 Diagonal Highway, Longmont, Colorado.

Status: Open.

Matters to be Considered: An update of the Corrections Annual Report, the Corrections Options Incentive Act, the Corrections Telecommunications System, the Foreign Technical Assistance, and the meeting on the Homeless Mentally Ill Inmates.

Contact Person for more Information: Larry Solomon, Deputy Director, (202) 307-3106.

M. Wayne Huggins,
Director.

[FR Doc. 92-13113 Filed 6-3-92; 8:45 am]

BILLING CODE 4410-36-M

DEPARTMENT OF LABOR

Occupational Safety and Health Administration

Shipyard Employment Standards Advisory Committee; Meeting

AGENCY: Occupational Safety and Health Administration (OSHA), Labor.

ACTION: Notice of meeting.

SUMMARY: Notice is hereby given that the Shipyard Employment Standards Advisory Committee, established under the provisions of the Federal Advisory Committee Act (FACA), as amended (5 U.S.C., App. I) and section 7(b) of the Occupational Safety and Health Act, 29 U.S.C. 656(b)), will convene on July 7, 1992, at 8:30 a.m., at the Boston Marriott Long Wharf, 296 State Street, Boston, Massachusetts, 02109. The meeting will adjourn on July 8, 1992, at approximately 4 p.m. The public is encouraged to attend.

The agenda is as follows:

- I. Call to Order.
- II. Review the transcripts of April 1-2, 1992 meeting.
- III. Discussion of the following standards:
 - (a) 29 CFR part 1915, Subpart F, General Working Conditions.
 - (b) Ad-hoc Committee Report on 29 CFR part 1915, Subpart G, Materials Handling and Storage (Hammerhead tower cranes).
 - (c) Ad-hoc Committee Report on 29 CFR part 1915, Subpart Q, Hazardous Materials (Process Safety Management).
 - (d) 29 CFR part 1915, Subpart L, Electrical 1915
 - (1) Temporary Services (Power/wiring)
 - (2) Scope and application (General)
 - (e) 29 CFR part 1915, Subpart U, Surface Preparation and preservation.
 - (f) Ad-hoc committee report on 29 CFR part 1915, Subpart Z, Lead.
- IV. New Business. Discussion of the following standards, as time permits.
 - (a) 29 CFR part 1915, subpart J, Ship's Machinery and Piping Systems.

Public Participation: Time permitting, the Committee will consider oral presentations relating to agenda items. Persons wishing to address the Committee should submit a written request to Mr. Thomas Hall (address below) by the close of business, June 26, 1992. The request must include the name and address of the person wishing to appear, the capacity in which the appearance will be made, a short summary of the intended presentation, and an estimate of the amount of time needed. Disabled individuals wishing to attend should contact Mr. Thomas Hall to obtain appropriate accommodations. Individuals or organizations wishing to submit written statements should send 5 copies to the address below.

FOR FURTHER INFORMATION CONTACT: Mr. Thomas Hall, U.S. Department of Labor, Occupational Safety and Health Administration, Office of Information and Consumer Affairs, room N-3647, 200 Constitution Avenue, NW., Washington, DC 20210, (202) 523-8617.

Signed at Washington, DC, this 1st day of June, 1992.

Dorothy L. Strunk,

Acting Assistant Secretary of Labor.

[FR Doc. 92-13121 Filed 6-3-92; 8:45 am]

BILLING CODE 4510-26-M

NATIONAL ARCHIVES AND RECORDS ADMINISTRATION

Records Schedules; Availability and Request for Comments

AGENCY: National Archives and Records Administration, Office of Records Administration.

ACTION: Notice of availability of proposed records schedules; request for comments.

SUMMARY: The National Archives and Records Administration (NARA) publishes notice at least once monthly of certain Federal agency requests for records disposition authority (records schedules). Records schedules identify records of sufficient value to warrant preservation in the National Archives of the United States. Schedules also authorize agencies after a specified period to dispose of records lacking administrative, legal, research, or other value. Notice is published for records schedules that (1) propose the destruction of records not previously authorized for disposal, or (2) reduce the retention period for records already authorized for disposal. NARA invites public comments on such schedules, as required by 44 U.S.C. 3303a(a).

DATE: Request for copies must be received in writing on or before July 20, 1992. Once the appraisal of the records is completed, NARA will send a copy of the schedule. The requester will be given 30 days to submit comments.

ADDRESSES: Address requests for single copies of schedules identified in this notice to the Records Appraisal and Disposition Division (NIR), National Archives and Records Administration, Washington, DC 20408. Requester must cite the control number assigned to each schedule when requesting a copy. The control number appears in the parentheses immediately after the name of the requesting agency.

SUPPLEMENTARY INFORMATION: Each year U.S. Government agencies create billions of records on paper, film, magnetic tape, and other media. In order to control this accumulation, agency records managers prepare records schedules specifying when the agency no longer needs the records and what happens to the records after this period. Some schedules are comprehensive and cover all the records of an agency or one of its major subdivisions. These comprehensive schedules provide for the eventual transfer to the National Archives of historically valuable records and authorize the disposal of all other records. Most schedules, however, cover records of only one office or program or a few series of records, and many are updates of previously approved schedules. Such schedules also may include records that are designated for permanent retention.

Destruction of records requires the approval of the Archivist of the United States. This approval is granted after a thorough study of the records that takes

into account their administrative use by the agency of origin, the rights of the Government and of private persons directly affected by the Government's activities, and historical or other value.

This public notice identifies the Federal agencies and their subdivisions requesting disposition authority, includes the control number assigned to each schedule, and briefly describes the records proposed for disposal. The records schedule contains additional information about the records and their disposition. Further information about the disposition process will be furnished to each requester.

Schedules Pending

1. Department of the Air Force (N1-AFU-92-23). Records of Special Honors, Trophies and Awards sponsored by Air Force and private organizations.

2. Department of Commerce, National Institute of Standards and Technology, (N1-167-92-2). Records of Malcolm Baldrige National Quality Award program.

3. Department of the Navy, U.S. Marine Corps, (N1-NU-92-3). Supporting documentation for personnel retention studies.

4. Department of the Navy, U.S. Marine Corps, (N1-NU-92-4). Facilitative records relating to rations.

5. Department of the Navy, U.S. Marine Corps, (N1-NU-92-5). Unit copy of Marine Corps diaries.

6. Department of the Navy, U.S. Marine Corps, (N1-NU-92-6). Material shortages case files.

7. Department of the Navy, U.S. Marine Corps, (N1-NU-92-7). Facilitative records relating to value engineering programs.

8. Department of the Navy, U.S. Marine Corps, (N1-NU-92-8). Facilitative records relating to medical and dental supplies.

9. Department of the Navy, U.S. Marine Corps, (N1-NU-92-9). Screening interviews of candidates for training schools.

10. Department of the Navy, U.S. Marine Corps, (N1-NU-92-10). Facilitative records relating to the Hometown Area Recruiting Program.

11. Department of Veterans Affairs, Veterans Health Administration (N1-15-92-3). Credentialing and privileging files for medical service individuals.

12. Central Intelligence Agency (N1-263-90-04). This CIA schedule is classified in the interests of national security pursuant to Executive Order 12356 and is further exempt from public disclosure pursuant to the National Security Act of 1947, 50 U.S.C. 403 (d)(3), and the CIA Act of 1949, 50 U.S.C. 403g.

13. Commission on the Bicentennial of the United States Constitution (N1-220-92-1). Routine and facilitative correspondence and other documentation, and educational grant programs.

14. Defense Civil Preparedness Agency (N1-397-91-2). Duplicative, unidentified and fragmentary maps depicting projected climatological fallout patterns, 1956-61.

15. Farm Credit Administration (N1-103-92-3). Examination reference files.

16. National Archives and Records Administration (N1-64-92-3). Records documenting service to National Archives by volunteers.

17. National Security Training Commission (N1-220-92-6). Routine and facilitative records relating to planning physical plant, and personnel matters.

18. Office of Civil and Defense Mobilization (N1-304-92-1). General administrative and mundane records of the Office of Civil and Defense Mobilization, Office of Defense Mobilization, Federal Civil Defense Administration and Defense Production Administration 1915-63.

Dated: May 27, 1992.

Don W. Wilson,

Archivist of the United States.

[FR Doc. 92-12985 Filed 6-3-92; 8:45 am]

BILLING CODE 7515-01-M

Nixon Presidential Historical Materials; Opening of Materials

AGENCY: National Archives and Records Administration.

ACTION: Notice of opening of materials.

SUMMARY: This notice announces the opening of additional files from the Nixon Presidential materials. Notice is hereby given that, in accordance with section 104 of Title I of the Presidential Recordings and Materials Preservation Act (88 Stat. 1695; 44 U.S.C. 2111 note) and section 1275.42(b) of the Public Access Regulations implementing the Act (36 CFR part 1275), the agency has identified, inventoried, and prepared for public access integral file segments of materials among the Nixon Presidential materials.

DATES: The National Archives intends to make the integral file segments described in this notice available to the public beginning July 24, 1992. In accordance with 36 CFR 1275.44, any person who believes it necessary to file a claim of legal right or privilege concerning access to these materials should notify the Archivist of the United States in writing of the claimed right, privilege, or defense before July 15, 1992.

ADDRESSES: The materials will be made available to the public at the National Archives' facility located at 845 South Picket Street, Alexandria, Virginia.

Petitions concerning access must be sent to the Archivist of the United States, National Archives and Records Administration, Washington, DC 20408.

FOR FURTHER INFORMATION CONTACT: Clarence F. Lyons, Jr., Acting Director, Nixon Presidential Materials Staff, 703-756-6498.

SUPPLEMENTARY INFORMATION: The integral file segments of textual materials to be opened consist of 47.1 cubic feet.

The White House Central Files Unit is a permanent organization within the White House complex that maintains a central filing and retrieval system for the records of the President and his staff. This is the eighth of a series of openings of Central Files: the previous openings were on December 1, 1986; March 22, 1988; December 9, 1988; July 17, 1989; December 15, 1989; August 22, 1991; and February 19, 1992.

Some of the materials designated for opening on July 24, 1992, are from the White House Central Files, Subject Files. The Subject Files are based on an alphanumeric file scheme of 61 primary subject categories. Listed below are the integral file segments from the White House Central Files, Subject Files that will be made available to the public on July 24, 1992.

Subject category	Volume (cubic feet)
Federal Government (FG):	
FG 231 United States Tariff Commission.....	.6
FG 249 Commission on All-Volunteer Armed Force.....	.6
FG 333 President's Committee on Health Education.....	.3

Six integral file segments from the Staff Member and Office Files will also be made available to the public. These consist of materials that were transferred to Central Files but were not incorporated into the Subject Files. Listed below are the Staff Member and Office Files that will be made available to the public on July 24, 1992.

File group	Volume (cubic feet)
Anne L. Armstrong.....	31.2
Michael P. Balzano.....	3.2
Howard C. Cohen.....	3.6
Lewis Engman.....	2.0
Darrell Trent.....	3.3

File group	Volume (cubic feet)
White House Conference on Aging.....	2.0

A number of documents which were previously withheld from public access have been reviewed and declassified under the Mandatory Review provisions of Executive Order 12356 and will be made available to the public on July 24, 1992.

	Volume (cubic feet)
Previously restricted materials.....	Less than .3.

Public access to some of the items in the file segments will be restricted as outlined in 36 CFR 1275.50 or 1275.52 (Public Access Regulations).

Dated: May 26, 1992.

Don W. Wilson,

Archivist of the United States.

[FR Doc. 92-12986 Filed 6-3-92; 8:45 am]

BILLING CODE 7515-01-M

NATIONAL ADVISORY COUNCIL ON THE PUBLIC SERVICE

Meetings

AGENCY: National Advisory Council on the Public Service.

ACTION: Notice of meeting.

DATE AND TIME: June 24, 1992, 8:45 a.m. to 4:30 p.m.

PLACE: National Press Building, 529 14th Street, NW., Washington, DC.

STATUS: Open.

MATTERS TO BE DISCUSSED:

Swearing-in of Council Members. Chairman Raymond Shafer's welcome and status of Council report.

Executive Director Curtis' report.

Overview of Public Law 101-363.

Status of the recommendations of the National Commission on the Public Service.

National Advisory Council on the Public Service (NACPS) agenda development.

NACPS public education plan.

FY-1993 programs and meetings schedule.

Council members' recommendations.

Public Comment.

FOR FURTHER INFORMATION CONTACT: Jane Riddleberger, NACPS, suite 420, National Press Building, 529 14th Street, NW., Washington, DC 20045 (202) 724-0796.

SUPPLEMENTARY INFORMATION: The National Advisory Council on the Public Service was established by Congress in

1990 by Public Law 101-363 [H.R. 4872]. The Council will regularly assess the state of the Federal workforce, seek to attract individuals of the highest caliber to national public service and promote a better understanding of the role of Federal employees in implementing government programs and policies. The Council will also seek to improve public perception of Federal employees, will encourage efforts to build student interest in public service and develops methods for improving motivation and encouraging excellence within the Federal workforce.

The Council shall transmit to the President and each House of the Congress reports with preliminary findings within year one and year two after the Council's first meeting. Within three years a final report containing a detailed statement of findings, conclusions and recommendations for legislative or administrative actions shall be transmitted.

Dated: June 1, 1992.

Jean M. Curtis,

Executive Director.

[FR Doc. 92-13102 Filed 6-3-92; 8:45 am]

BILLING CODE 7525-01-M

NATIONAL COMMISSION ON MIGRANT EDUCATION

Meeting

ACTION: Notice of meeting.

SUMMARY: The National Commission on Migrant Education will hold its eighteenth meeting on Monday, June 22, 1992. The Commission was established by Public Law 100-297, April 28, 1988.

DATE, TIME, AND PLACE: Monday, June 22, 1992, 8:30 a.m. to 5:30 p.m., at the Bethesda Ramada, 8400 Wisconsin Avenue, Bethesda, MD 20814.

STATUS: Open to the public.

AGENDA: Consultant's briefing on the chapter 2 (Demographics) draft of the Commission's final report. Remainder of time will be devoted to discussion of draft findings and recommendations for the Commission's final report.

FOR FURTHER INFORMATION CONTACT: Elizabeth J. Skiles (301) 492-5336, National Commission on Migrant Education, 8120 Woodmont Avenue, Fifth Floor, Bethesda, Maryland 20814. Linda Chavez, Chairman.

[FR Doc. 92-13060 Filed 6-3-92; 8:45 am]

BILLING CODE 6820-DE-M

NATIONAL SCIENCE FOUNDATION

Special Emphasis Panel in Networking and Communications Research and Infrastructure; Meeting

In accordance with the Federal Advisory Committee Act (Pub. L. 92-463, as amended), the National Science Foundation announces the following meeting:

Name: Special Emphasis Panel in Networking and Communications Research and Infrastructure.

Date and Time: June 24-25, 1992; 8:30 a.m. to 5 p.m.

Place: Room 500-B, National Science Foundation, 1110 Vermont Avenue, NW., Washington, DC 20550.

Type of Meeting: Closed.

Contact Person: Dr. George Strawn, NSFNET Program, National Science Foundation, room 416, Washington, DC 20550 (202 357-9717).

Purpose of Meeting: To provide advice and recommendations concerning proposals submitted to NSF for financial support.

Agenda: To review and evaluate proposals submitted for the Network Information Services Manager(s) for NSFNET and the NREN Project Solicitation.

Reason for Closing: The proposals being reviewed include information of a proprietary or confidential nature, including technical information; financial data, such as salaries, and personal information concerning individuals associated with the proposals.

These matters are exempt under 5 U.S.C. 552b. (c) (4) and (6) of the Government in the Sunshine Act.

Dated: May 29, 1992.

M. Rebecca Winkler,

Committee Management Officer.

[FR Doc. 92-12995 Filed 6-3-92; 8:45 am]

BILLING CODE 7555-01-M

NUCLEAR REGULATORY COMMISSION

Documents Containing Reporting or Record Keeping Requirements: Office of Management and Budget (OMB) Review

AGENCY: Nuclear Regulatory Commission (NRC).

ACTION: Notice of OMB review of information collection.

SUMMARY: The Nuclear Regulatory Commission has recently submitted to OMB for review the following proposal for the collection of information under

the provisions of the Paperwork Reduction Act (44 U.S.C. chapter 35).

1. *Type of Submission, New, Revision, or Extension:* Extension.

2. *The Title of the Information Collection:* Request for Records.

3. *The Form Number if Applicable:* NRC Form 57.

4. *How often the Collection is Required:* On occasion.

5. *Who Will be Required or Asked to Report:* Individuals requesting Public Document Room (PDR) documents.

6. *An Estimate of the Number of Responses:* 45,000 per year.

7. *An Estimate of the Total Number of Hours to Complete the Requirement or Request:* 750 hours annually (45,000 forms X .01666 hr/form) or about 1 minute per individual.

8. *An Indication of Whether Section 3504(h), Public Law 96-511 Applies:* Not applicable.

9. *Abstract:* This form is utilized by the public in the Public Document Room (PDR) in requesting documents for their use at the PDR; this form then serves as a suspense slip on the shelf when the document is charged out to a member of the public.

Copies of the submittal may be inspected or obtained for a fee from the NRC Public Document Room, Lower Level, 2120 L Street, NW., Washington, DC.

Comments and questions can be directed by mail to the OMB reviewer: Ronald Minsk, Office of Information & Regulatory Affairs (3150-0063), NEOB-3019, Office of Management and Budget, Washington, DC 20503.

Comments can also be communicated by telephone at (202) 395-3084.

The NRC Clearance Officer is Brenda Jo. Shelton, (301) 492-8132.

Dated at Bethesda, Maryland, this 22 day of May, 1992.

For the Nuclear Regulatory Commission.
George H. Messenger,

Acting Designated, Senior Official for Information Resources Management.

[FR Doc. 92-13063 Filed 6-3-92; 8:45 am]

BILLING CODE 7590-01-M

Documents Containing Reporting or Recordkeeping Requirements: Office of Management and Budget (OMB) Review

AGENCY: Nuclear Regulatory Commission (NRC).

ACTION: Notice of the OMB review of information collection.

SUMMARY: The Nuclear Regulatory Commission has recently submitted to OMB for review the following proposal

for collection of information under the provisions of the Paperwork Reduction Act (44 U.S.C. chapter 35).

1. *Type of Submission—New, Revision, or Extension:* Revision.

2. *The Title of the Information Collection:* 10 CFR parts 2, 40, 70 and 74 Material Control and Accounting for Uranium Enrichment Facilities Authorized to Produce Special Nuclear Material of Low Strategic Significance.

3. *The For Number if Applicable:* Not applicable.

4. *How Often is the Collection Required:* Information on missing uranium or unauthorized production of enriched uranium is estimated to be collected at a frequency of once per 5 years.

5. *Who Will be Required or Asked to Report:* Applicants for license or licensees authorized to possess equipment capable of enriching uranium or to operate an enrichment facility and produce, possess, or use more than one effective kilogram of special nuclear material of low strategic significance.

6. *An Estimate of the Number of Responses:* 0.2.

7. *An Estimate of the Number of Hours Annually Needed to Complete the Requirement or Request:* 16 hours (80 hours per response).

8. *An Indication of Whether Section 3504(h), Public Law 96-511 Applies:* Applicable.

9. *Abstract:* The final rule has added new requirements which would require an applicant for license or a licensee authorized to possess equipment capable of enriching uranium, or operate an enrichment facility, and produce, possess, or use more than one effective kilogram of special nuclear material of low strategic significance, to provide information to aid in the investigation of missing uranium, or unauthorized production of enriched uranium.

Copies of the submittal may be inspected or obtained for a fee from the NRC Public Document Room, 2120 L Street, NW. (Lower Level), Washington, DC 20555.

Comments and questions can be directed by mail to the OMB reviewer: Ronald Minsk, Office of Information and Regulatory Affairs (3150-0123), NEOB-3019, Office of Management and Budget, Washington, DC 20503.

Comments can also be submitted by telephone at (202) 395-3084.

The NRC Clearance Officer is Brenda Jo Shelton, (301) 492-8132.

Dated at Bethesda, Maryland, this 22nd day of May, 1992.

For the Nuclear Regulatory Commission.
George H. Messenger,
Acting Designated Senior Official for
Information Resources Management.
[FR Doc. 92-13064 Filed 6-3-92; 8:45 am]
BILLING CODE 7590-01-M

OFFICE OF SCIENCE AND TECHNOLOGY POLICY

Meeting of the President's Council of Advisors on Science and Technology

ACTION: Amended notice of meeting.

SUMMARY: The President's Council of Advisors on Science and Technology will meet on June 4-5, 1992, in the Conference Room, Council on Environmental Quality, 722 Jackson Place NW., Washington, DC., as announced in 57 FR 21141 (May 18, 1992). All information in this previous *Federal Register* Notice will remain the same with the exception of one agenda item listed in the next section.

AGENDA: Mr. Edwin Mansfield was previously scheduled to make a presentation on the Return on R&D Investment during the Thursday morning session. Mr. Mansfield will not be available to make this presentation. Therefore, during the Thursday morning session, Dr. Walter Dowdle will make a presentation on the current status of AIDS Vaccine Research. In addition, Dr. Roy Schwitters will make a presentation on the current status of the Superconducting Super Collider.

All other agenda items, including topics, time, place and status of the meetings will remain the same. Parties requiring further information should contact Ms. Ann Barnett, (202) 395-4692.

Dated: May 29, 1992.
Vickie V. Sutton,
Assistant Director, Office of Science and
Technology Policy.
[FR Doc. 92-13022 Filed 6-3-92; 8:45 am]
BILLING CODE 3170-01-M

The President's Council of Advisors on Science and Technology

ACTION: Notice of public meetings.

SUMMARY: The President's Council of Advisors on Science and Technology (PCAST), will hold a series of public meetings around the country over the next few months to gather information for its study of research intensive universities and their relationships with the Federal government. These meetings will be sponsored by PCAST and a host institution, such as, various colleges and universities nationwide and the National Academy of Sciences.

The purpose of the PCAST public meetings is primarily educational. The goal is to utilize the information gathered from the public meetings and incorporated relevant information into a report on research intensive universities and their relationships with the Federal government. Discussion topics are expected to include the following:

(1) Capacity of research-intensive universities to fulfill their missions in research, education and public service; principal concerns, suggested remedies.

(2) Nature of the current relationship between research-intensive universities and the Federal government; changes occurring or in view; principal problems or areas of difficulty; suggestions for improvement.

(3) Key elements or principles that should characterize the relationship between research-intensive universities and the Federal and/or State governments in the coming years.

(4) The most pressing challenges confronting research-intensive universities over the next decade; role, if any, for the Federal government.

(5) Concerns regarding physical facilities for research: realistic needs, barriers (e.g., limits to campus expansion), role of institutions, States, Federal government in financing.

(6) Balancing merit-based peer review with other criteria for supporting research.

(7) General commitment expected of the Federal government to the university-base pool of highly trained scientists and engineers.

(8) The Federal government's role in expanding the number of university-based women and minorities in science and engineering.

The PCAST seeks diverse perspectives from a broad range of individuals including students and representatives from academia, industry, state government, associations and other interested parties. PCAST also welcomes comments on topics other than those listed above. However, the main purpose of these public meetings is to examine research in colleges and universities, and comments should be directed toward this goal.

DATES AND LOCATIONS: The following is a list of dates and locations of the public meetings:

Date	Place	Host institution
6/24/92	Cambridge, MA.....	Massachusetts Institute of Technology.
7/15/92	Berkeley, CA.....	University of California.
7/17/92	Austin, TX.....	University of Texas.

Date	Place	Host institution
7/21/92	Durham, NC	Duke University.
7/24/92	Washington, DC (higher education associations).	National Academy of Sciences.
9/24/92	Chicago, IL	Northwestern University.

The June 24, 1992, meeting at the Massachusetts Institute of Technology in Cambridge, MA will be held in building E51, room 329, 70 Memorial Drive. The building is on the corner of Wadsworth and Amherst Streets and attendees should use the entrance on Amherst Street. The meeting will begin at 9 a.m., and is expected to last until 4 p.m. Registration will be from 8:30 a.m. to 9 a.m., as outlined in the following Agenda Section.

Specific locations for the remainder of the PCAST meetings will be published in the **Federal Register** once they have been determined. In addition, should it become necessary to change a specific date or location listed above, that information will also be published in the **Federal Register**.

Agenda: Each meeting will be structured based on the following agenda schedule:

- 8:30 a.m.—Arrival are Welcome
- 9 a.m.—Host institution welcome
- PCAST representative presents brief overview
- 9:15 a.m.—Presentation: College/university administration
- 10:15 a.m.—Presentation: College/university faculty
- 11:30 a.m.—Presentation: College/university students (graduate/undergraduate)
- 12:30 p.m.—Lunch
- 1:30 p.m.—Presentation: Industry/state government
- 2:30 p.m.—Presentation: Public input
- 3:30 p.m.—Wrap-up/Closing remarks

The PCAST members will attempt to adhere to this schedule at each public meeting site. However, presentation times may be shortened or lengthened depending on interest expressed by each group at each public meeting site.

How to Register: To register to attend any of the meetings, contact Ms. Alicia Tenuta, Office of Science and Technology Policy, 744 Jackson Place, NW., Washington, DC 20506 at (202) 395-4692, fax number (202) 395-5076. Advance registration is desirable for those who wish to make oral presentations. On-site registration will also be held on the days of the meeting from 8:30 a.m. to 9 a.m. There is no registration fee.

Oral Presentations: Individuals or representatives of organizations are

encouraged to make oral presentations and/or to submit written statements to the PCAST for its study.

An individual or representative of an organization wishing to make an oral presentation (limited to 5 minutes) should submit his or her name, position, affiliation, phone and fax numbers, address, and the general topic area of the comments to Alicia Tenuta at the above address or fax no later than 10 days prior to each meeting date.

Written Comments: Written comments are also encouraged, especially for those who are not able to attend a public meeting. Written comments should be no more than 10 pages in length, typed and double spaced. It would be most helpful if comments are received as soon as possible, but PCAST will accept input until August 1, 1992.

FOR FURTHER INFORMATION CONTACT: Ms. Alicia Tenuta at the above address and phone number.

Dated: May 29, 1992

Vickie V. Sutton,

Assistant Director, Office of Science and Technology Policy.

[FR Doc. 92-13021 Filed 6-3-92; 8:45 am]

BILLING CODE 3170-01-M

OFFICE OF THE UNITED STATES TRADE REPRESENTATIVE

(Docket No. 301-89)

Initiation of Section 302 Investigation and Request for Public Comment: Intellectual Property Acts, Policies, and Practices on Taiwan

AGENCY: Office of the United States Trade Representative.

ACTION: Notice of initiation of investigation pursuant to section 302(b)(2)(A) of the Trade Act of 1974, as amended; request for written comments.

SUMMARY: The United States Trade Representative (USTR) has initiated an investigation pursuant to section 302(b)(2)(A) of the Trade Act of 1974, as amended (the Trade Act), with respect to certain acts, policies and practices of the authorities on Taiwan that deny adequate and effective protection of intellectual property rights. USTR invites written comments from the public concerning the matters being investigated.

DATES: This investigation was initiated on May 29, 1992. Written comments from the public are due on or before 12:00 noon, Monday, July 6, 1992.

FOR FURTHER INFORMATION CONTACT: Laura Kneale Anderson, Director for Taiwan, (202) 395-6813; Emery Simon,

Deputy Assistant USTR for Intellectual Property (202) 395-6884; or Catherine Field, Associate General Counsel, (202) 395-3432, Office of the United States Trade Representative.

SUPPLEMENTARY INFORMATION: Section 182(a) of the Trade Act (19 U.S.C. 2242) requires the USTR to identify trading partners that deny adequate and effective protection or enforcement of intellectual property rights or that deny fair and equitable market access to U.S. persons that rely on intellectual property protection. Accordingly, on April 29, 1992, the USTR identified Taiwan as a "priority foreign country" under that provision. In identifying Taiwan as a "priority foreign country," the USTR noted deficiencies in that trading partner's intellectual property acts, policies, and practices with respect to: (1) Effective enforcement of intellectual property rights, in particular, the grant of effective remedies against infringement of copyright and trademarks; (2) the high level of exports worldwide of goods from Taiwan that infringe intellectual property rights; and (3) the level of protection provided under laws and agreements for owners of U.S. patents, copyrights, trade secrets, layout designs of integrated circuits, and industrial designs.

Investigation and Consultations

Section 302(b)(2)(A) of the Trade Act requires the USTR to initiate an investigation of any act, policy, or practice that was the basis of the identification of a country as a priority foreign country under the provisions of section 182(a)(2) of the Trade Act to determine whether such act, policy, or practice is actionable under section 301 of the Trade Act.

Pursuant to section 303(a) of the Trade Act, the USTR has requested consultations with representatives of the authorities on Taiwan concerning the issues under investigation. USTR will seek information and advice from the appropriate committees provided for under section 135 of the Trade Act in preparing presentations for such consultations.

Within six months after the date on which this investigation was initiated (i.e., on or before November 29, 1992), pursuant to section 304 of the Trade Act, the USTR must determine, on the basis of the investigation and the consultations, whether any act, policy, or practice described in section 301 of the Trade Act exists and, if that determination is affirmative, determine what action, if any, to take under section 301 of the Trade Act. The deadline for making these

determinations may, however, be extended to nine months after the date of initiation of this investigation if the USTR determines that complex or complicated issues are involved in the investigation that require additional time, that the authorities on Taiwan are making substantial progress in drafting or implementing legislative or administrative measures that will provide adequate and effective protection of intellectual property rights, or that the authorities on Taiwan are undertaking enforcement measures to provide adequate and effective protection of intellectual property rights.

Requirements for Submissions

Interested persons are invited to submit written comments concerning the acts, policies and practices of the authorities on Taiwan that are the subject of this investigation; the amount of burden or restriction on U.S. commerce caused by these acts, policies and practices; and the determinations required under section 304 of the Trade Act.

Comments must be filed in accordance with the requirements set forth in 15 CFR 2006.8(b) (55 FR 20593) and are due no later than 12 noon, Monday, July 6, 1992. Comments must be in English and provided in twenty copies to: Chairman, Section 301 Committee, room 223, USTR, 600 17th Street, NW., Washington, DC 20506.

Comments will be placed in a file (Docket 301-89) open to public inspection pursuant to 15 CFR 2006.13, except confidential business information exempt from public inspection in accordance with 15 CFR 2006.15. Confidential business information submitted in accordance with 15 CFR 2006.15 must be clearly marked "Business Confidential" in a contrasting color ink at the top of each page on each of 20 copies, and must be accompanied by a nonconfidential summary of the confidential information. The nonconfidential summary shall be placed in the docket which is open to public inspection.

Jeanne E. Davidson,
Chairman, Section 301 Committee.

[FR Doc. 92-13125 Filed 6-3-92; 8:45 am]

BILLING CODE 3190-01-M

THE PRESIDENTIAL COMMISSION ON THE ASSIGNMENT OF WOMEN IN THE ARMED FORCES

Meeting

Summary: This 15 member Commission will hear 2 days of testimony from military services and

civilians on policies pertaining to the Assignment of Women in the Military. Additionally, time will be available at hearings for the Commission's four Fact Finding Panels who will meet to discuss:

1. Foreign Military and Domestic Law Enforcement Agency Experience;
2. Equipment Facilities, Accommodations;
3. The Conscripted Environment, and the Effects of Changes in Combat Exclusion Restrictions on Career Opportunities, Recruitment, Retention.

Dates: Monday, June 8th and Tuesday, June 9th, 8 a.m. to 6 p.m.
Address: Embassy Suites Hotel, 1250 22ND Street, NW., Rooms: Diplomat/Consulate, Washington, DC 20037, (202)857-3388.

Status: Open.

Contact: Magee Whelan or Kevin K. Kirk (202) 376-6905.

W. S. Orr,

Staff Director.

[FR Doc. 92-12997 Filed 6-3-92; 8:45 am]

BILLING CODE 6820-CD-M

PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

Meeting

Notice is hereby given of the meeting of the Prospective Payment Assessment Commission on Tuesday, June 16, 1992, at the Madison Hotel, 15th & M streets, Northwest, Washington, DC.

The full commission will convene at 9 a.m. in executive chambers 1, 2 and 3. All meetings are open to the public.

Donald A. Young,
Executive Director.

[FR Doc. 92-13074 Filed 6-3-92; 8:45 am]

BILLING CODE 6820-BW-M

SECURITIES AND EXCHANGE COMMISSION

[Rel. No. IC-18735; 811-5504]

Mills Value Fund, Inc.; Notice of Application for Deregistration

May 28, 1992.

AGENCY: Securities and Exchange Commission ("SEC").

ACTION: Notice of Application for Deregistration under the Investment Company Act of 1940 (the "Act").

APPLICANT: Mills Value Fund, Inc. (the "Fund").

RELEVANT ACT SECTION: Section 8(f).

SUMMARY OF APPLICATION: Applicant seeks an order declaring that it has ceased to be an investment company.

FILING DATE: The application was filed on March 25, 1992 and amended on May 22, 1992.

HEARING OR NOTIFICATION OF HEARING: An order granting the application will be issued unless the SEC orders a hearing. Interested persons may request a hearing by writing to the SEC's Secretary and serving applicant with a copy of the request, personally or by mail. Hearing requests should be received by the SEC by 5:30 p.m. on June 22, 1992, and should be accompanied by proof of service on the applicant, in the form of an affidavit or, for lawyers, a certificate of service. Hearing requests should state the nature of the writer's interest, the reason for the request, and the issues contested. Persons who wish to be notified of a hearing may request notification by writing to the SEC's Secretary.

ADDRESSES: Secretary, SEC, 450 Fifth Street, NW., Washington, DC 20549. Applicant, 1108 East Main Street, Richmond, Virginia 23219.

FOR FURTHER INFORMATION CONTACT: Marc Duffy, Staff Attorney, (202) 272-2511, or C. David Messman, Branch Chief, (202) 272-3018 (Division of Investment Management, Office of Investment Company Regulation).

SUPPLEMENTARY INFORMATION: The following is a summary of the application. The complete application may be obtained for a fee from the SEC's Public Reference Branch.

Applicant's Representations

1. The fund is an open-end diversified management company incorporated under Virginia law. Anderson & Strudwick is the Fund's principal underwriter and sponsor (the "Sponsor"). On March 18, 1988, the Fund registered under the Act by filing a Notification of Registration pursuant to section 8(a). On this same date, the Fund filed a registration statement on Form N-1A, pursuant to section 8(b) of the Act, and registered an indefinite number of shares under the Securities Act of 1933. The registration statement was declared effective on July 29, 1988, and the Fund's initial public offering commenced on August 19, 1988.

2. On October 22, 1991, the Board of Directors of the Fund recommended that a plan of dissolution and liquidation (the "Plan") be submitted to the shareholders of the Fund. On December 2, 1991, proxy materials relating to the Plan were filed with the SEC. At a special meeting held on December 27, 1991, 73% of the shares outstanding voted in favor of the Plan.

3. On December 27, 1991, the Fund made liquidating distributions to its

shareholders. Each shareholder, other than the Sponsor, received a distribution in an amount equal to such shareholder's *pro rata* portion of the net assets of the Fund. The Fund's shareholders, other than the Sponsor, received \$11.26 per share.

4. The Fund's organizational expenses were being deferred and amortized on a straight line basis over 60 months. At the time of liquidation, the Fund had remaining unamortized organizational expenses of \$31,666.86. Because the Sponsor bore the Fund's unamortized organizational expenses, it received a liquidating distribution of \$3.53 per share.

5. Expenses in the amount of \$18,440.68 were incurred in connection with the liquidation and dissolution of the Fund. The Fund's investment adviser, Mill Value Advisers, Inc., bore these expenses.

6. At the time of filing of the application, the Fund had no shareholders, assets, or liabilities. The Fund is not a party to any litigation or administrative proceedings. The Fund is not engaged, nor does it propose to engage, in any business activities other than those necessary for the winding up of its affairs.

For the SEC by the Division of Investment Management, under delegated authority.
Margaret H. McFarland;

Deputy Secretary.

[FR Doc. 92-13005 Filed 6-3-92; 8:45 am]

BILLING CODE 8010-01-M

SMALL BUSINESS ADMINISTRATION

[Declaration of Disaster Loan Area #2561]

Virginia; Declaration of Disaster Loan Area

As a result of the President's major disaster declaration on May 19, 1992, I find that the Counties of Albermarle, Amherst, Augusta, Bedford, Botetourt, Carroll, Craig, Floyd, Franklin, Greene, Montgomery, Nelson, Page, Patrick, Pulaski, Rappahannock, Roanoke, Rockbridge, Rockingham, and Warren, and the Cities of Buena Vista, Roanoke, and Salem in the State of Virginia constitute a disaster area as a result of damages caused by severe storms and flooding on April 21-22, 1992. Applications for loans for physical damage may be filed until the close of business on July 17, 1992, and for loans for economic injury until the close of business on February 19, 1993, at the address listed below: U.S. Small Business Administration, Disaster Area 2 Office, One Baltimore Place, suite 300, Atlanta, Georgia 30308, or other locally

announced locations. In addition, applications for economic injury loans from small businesses located in the contiguous Counties of Allegheny, Appomattox, Bath, Bland, Buckingham, Campbell, Clarke, Culpeper, Fauquier, Fluvanna, Frederick, Giles, Grayson, Henry, Highland, Louisa, Madison, Orange, Pittsylvania, Shenandoah, and Wythe, and the Cities of Bedford, Charlottesville, Galax, Harrisonburg, Lexington, Lynchburg, Radford, Staunton, and Waynesboro in the State of Virginia; Hardy, Monroe, and Pendleton Counties in the State of West Virginia; and Rockingham, Stokes, and Surry Counties in the State of North Carolina may be filed until the specified date at the above location.

The interest rates are:

	Percent
For physical damage:	
Homeowners with credit available elsewhere	8.000
Homeowners without credit available elsewhere	4.000
Businesses with credit available elsewhere	6.500
Businesses and non-profit organizations without credit available elsewhere	4.000
Others (including non-profit organizations) with credit available elsewhere	8.500
For economic injury:	
Businesses and small agricultural cooperatives without credit available elsewhere	4.000

The number assigned to this disaster for physical damage is 256106 and for economic injury the numbers are 762800 for Virginia; 763000 for West Virginia; and 763100 for North Carolina.

(Catalog of Federal Domestic Assistance Program Nos. 59002 and 59008)

Dated: May 26, 1992.

Bernard Kulik,

Assistant Administrator for Disaster Assistance.

[FR Doc. 92-13088 Filed 6-3-92; 8:45 am]

BILLING CODE 8025-01-M

[License No. 02/02-5467]

Yusa Capital Corp.; Surrender of License

Notice is hereby given that, pursuant to Section 107.105 of the Small Business Administration (SBA) Rules and Regulations governing Small Business Investment Companies (13 CFR 107.105 (1992)), Yusa Capital Corporation, 622 Broadway, New York, NY 10012, incorporated under the laws of the State of New York has surrendered its license, No. 02/02-5467 issued by the SBA on July 31, 1984.

Yusa Capital Corporation has complied with all conditions set forth by SBA for surrender of its license. Therefore, under the authority vested by the Small Business Investment Act of 1958, as amended, and pursuant to the above-cited Regulation, the license of Yusa Capital Corporation is hereby accepted and it is no longer licensed to operate as a Small Business Investment Company.

(Catalog of Federal Domestic Assistance Program No. 59.011, Small Business Investment Companies)

Dated: May 2, 1992.

Wayne S. Foren,

Associate Administrator for Investment,
[FR Doc. 92-13087 Filed 6-3-92; 8:45 am]

BILLING CODE 8025-01-M

Region I Advisory Council; Public Meeting

The U.S. Small Business Administration Region I Advisory Council, located in the geographical area of Hartford, will hold a public meeting at 8:30 a.m. on Monday, July 13, 1992 at the Days Inn, 900 East Main Street, Meriden, Connecticut, to discuss such matters as may be presented by members, staff of the U.S. Small Business Administration, or others present.

For further information, write or call Carol A. White, District Director, U.S. Small Business Administration, 330 Main Street, Hartford, Connecticut 06106, (203) 240-4670.

Dated: May 26, 1992.

Caroline J. Beeson,

Assistant Administrator, Office of Advisory Councils.

[FR Doc. 92-13084 Filed 6-3-92; 8:45 am]

BILLING CODE 8025-01-M

[Delegation of Authority No. 12-A (Revision 5; Amdt. 1)]

Delegation of Authority; Redefinition of Financial Assistance

Delegation of Authority No. 12-A (Revision 5) (56 FR 55147 October 24, 1991) is hereby amended by Delegation of Authority No. 12-A (Revision 5; Amendment 1). This amendment delegates authority from the Administrator to certain SBA personnel to conduct a Microloan Demonstration Program as added to the Small Business Act by Public Law 102-140, the Commerce, Justice, and State, the Judiciary, and Related Agencies Appropriations Act of 1991. Specifically, Public Law 102-140 added a new

subsection (m) to section 7 of the Small Business Act, 15 U.S.C. 636(m), which established a program by which SBA would make direct loans to intermediaries who will use the proceeds to make microloans to startup, newly established, or growing small business concerns. Delegation of Authority No. 12-A (Revision 5; Amendment 1) reads as follows:

1. Regarding the authority delegated to the Assistant Administrator for Financial Assistance: on page 55148, in the third column, paragraphs I.A.6. and 7. are redesignated as paragraphs I.A.7. and 8., and a new paragraph I.A.6. is added to read as follows:

I. Pursuant to the action of the Administrator, Small Business Administrator, dated February 12, 1990, the following authority is hereby delegated to the specific positions designated herein as follows:

A. To the Assistant Administrator for Financial Assistance as follows:

6. Microloan Demonstration Program

a. To take any and all actions involved in approval or decline of applications of entities seeking to be intermediaries in the Microloan Demonstration Program pursuant to section 7(m) of the Small Business Act, 15 U.S.C. 636(m).

b. To take any and all actions involved in the approval or decline of applications for a direct loan by intermediaries approved to participate in the Microloan Demonstration Program, the proceeds of which are to be used to make microloans to qualified small business concerns, including reconsideration thereof; and to execute authorizations and modifications pertaining to such direct loans.

c. To take any other actions necessary to implement the Microloan Demonstration Program as set forth in section 7(m) of the Small Business Act, 15 U.S.C. 636(m) and the regulations promulgated thereunder, See 13 CFR 121.61.

2. Regarding the authority delegated to the Director, Office of Financing: on page 55149, in the first column, paragraph I.B.4. is redesignated as paragraph I.B.5., and a new paragraph I.B.4. is added to read as follows:

I. Pursuant to the action of the Administrator, Small Business Administrator, dated February 12, 1990, the following authority is hereby delegated to the specific positions designated herein as follows:

B. To the Director, Office of Financing as follows:

4. Microloan Demonstration Program

a. To take any and all actions involved in approval or decline of applications of entities seeking to be intermediaries in the Microloan Demonstration Program pursuant to section 7(m) of the Small Business Act, 15 U.S.C. 636(m).

b. To take any and all actions involved in the approval or decline of applications for a direct loan by intermediaries approved to participate in the Microloan Demonstration Program, the proceeds of which are to be used to make microloans to qualified small business concerns, including reconsideration thereof; and to execute authorizations and modifications pertaining to such direct loans.

c. To take any other actions necessary to implement the Microloan Demonstration Program as set forth in section 7(m) of the Small Business Act, 15 U.S.C. 636(m) and the regulations promulgated thereunder, See 13 CFR 121.61.

Dated: May 18, 1992.

Patricia Saiki,
Administrator.

[FR Doc. 92-13085 Filed 6-3-92; 8:45 am]

BILLING CODE 8025-01-M

[License No. 02/02-5266]

EQUICO Capital Corp.; Transfer of Ownership and Control of a Small Business Investment Company License

On April 16, 1992, a notice was published in the *Federal Register* (57 FR 92-8812) stating that an application has been filed by EQUICO Capital Corporation, 135 West 50th Street, suite 1170, New York, New York 10020, with the Small Business Administration (SBA) pursuant to § 107.102 of the Regulations governing small business investment companies (23 CFR 107.102 (1992)) for a Transfer of Ownership and Control of the Small Business Investment Company License.

Interested parties were given until close of business May 1, 1992 to submit their comments to SBA. No comments were received.

Notice is hereby given that, pursuant to section 301(d) of the Small Business Investment Act of 1958, as amended, after having considered the application and all other pertinent information, SBA approved the Transfer of Ownership and Control of EQUICO Capital

Corporation, on May 14, 1992. Upon the change of Ownership and Control, EQUICO Capital Corporation will change its name to TSG Ventures, Inc.

(Catalog of Federal Domestic Assistance Program No. 59.011, Small Business Investment Companies)

Dated: May 21, 1992.

Wayne S. Foren,

Associate Administrator for Investment.

[FR Doc. 92-13086 Filed 6-3-92; 8:45 am]

BILLING CODE 8025-01-M

DEPARTMENT OF STATE

Bureau of Consular Affairs

[Public Notice 633]

Certain Foreign Passports Validity

Under the provisions of 212(a)(7)(B), formerly 212(a)(26), of the Immigration and Nationality Act, a nonimmigrant alien who makes application for a visa or for admission into the United States is required to possess a passport which is: (1) Valid for a minimum period of six months from the date of expiration of the initial period of the alien's admission into the United States or his or her contemplated initial period of stay and (2) authorizes the alien to return to the country from which he or she came or to proceed to and enter some other country during such period. Because of the foregoing requirement, certain foreign governments have entered into agreements with the Government of the United States whereby their passports are recognized as valid for the return of the bearer to the country of the foreign issuing authority for a period of six months beyond the expiration date specified in the passport. These arrangements have the effect of extending the validity period of the foreign passport an additional six months notwithstanding the expiration date indicated in the passport.

This Public Notice advises the public that Suriname is now among those countries which have concluded such agreements.

The following governments have concluded agreements with the Government of the United States:

Algeria
Antigua and Barbuda
Australia
Austria (Reisepass only)
Bahamas, The
Bangladesh (travel permits and passports)
Belgium
Bolivia
Brazil
Canada
Chile

Colombia
Cost Rica
Cote d'Ivoire
Cuba
Cyprus
Denmark
Dominican Republic
Ecuador
Egypt
El Salvador
Ethiopia
Finland
France
Germany
Greece
Grenada
Guatemala
Guinea
Guyana
Honduras
Hong Kong (Certificates of Identity and
passports)
Iceland
India
Iran
Ireland
Israel
Italy
Jamaica
Japan
Jordan
Korea
Kuwait
Laos
Lebanon
Libya
Liechtenstein
Luxembourg
Madagascar
Malaysia
Malta
Mauritius
Mexico
Monaco
Morocco
Netherlands
New Zealand
Nicaragua (diplomatic and official passports
only)
Nigeria
Norway
Pakistan
Panama
Paraguay
Peru
Philippines
Poland
Portugal
Qatar
St. Kitts and Nevis
St. Lucia
St. Vincent and the Grenadines
Senegal
Singapore
Soviet Union (USSR) (Seamen only)
Spain
Sri Lanka
Sudan
Suriname
Sweden
Switzerland
Syria
Thailand
Trinidad and Tobago
Tunisia
Turkey

United Arab Emirates
United Kingdom
Uruguay
Venezuela
Yugoslavia

In addition, travel documents issued by the Government of the Trust Territory of the Pacific Islands are considered to be valid for the return of the bearer to the Trust Territory for a period of six months beyond the expiration date specified therein.

Public Notice 954 of February 26, 1986 issued at 51 FR 6853 is hereby superseded.

Dated: May 22, 1992.

Elizabeth M. Tamposi,

Assistant Secretary for Consular Affairs.

[FR Doc. 92-13112 Filed 6-3-92; 8:45 am]

BILLING CODE 4710-06-M

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

Airway Science Grant Proposals

AGENCY: Federal Aviation Administration, DOT.

ACTION: Extension of closing date for notice of solicitation for airway science grant proposals.

SUMMARY: The solicitation published in the *Federal Register* (57 FR 9586, March 19, 1992) represents a continuation of the Federal Aviation Administration's AWS Grant Program. The Federal Aviation Administration (FAA) is authorized by Public Laws 101-516 and 102-143 to solicit competitive proposals for Airway Science (AWS) grants from accredited 4-year public or nonprofit private colleges and universities with recognized FAA AWS Curriculum programs. The FAA expects to award most, if not all, of an available \$5,036,384 in the form of grants, to a select number of these recognized institutions. A portion of the available funds will be awarded to eligible minority institutions with recognized AWS curricula. Awards typically will range from \$100,000 to a maximum of \$300,000. In no event shall the total Federal share of any AWS project exceed 50% of the cost of the project.

The grant funds may be used for the purchase, lease with intent to purchase, or construction of academic buildings and associated facilities to be used in support of an FAA recognized AWS curriculum. In addition, grant funds may be used for nonexpendable instructional materials or instructional equipment to be used in the actual teaching of the AWS curriculum. No federal grant funds shall be used for salaries, operating

expenses, research and development, travel, consultant fees, indirect costs, office supplies or other expendable items, automobiles, aircraft, maintenance agreements, printing costs, promotional and marketing materials or equipment, general purpose parking lots, land, commercial airport facilities, taxiways, runways, or any project in support of a commercial activity.

FOR FURTHER INFORMATION CONTACT:

Virginia Hancock Krohn, Manager, Airway Science Grant Program, Federal Aviation Administration, Office of Training and Higher Education, AHT-30, room PL-100, 400 7th Street SW., Washington, DC 20590, Telephone: (202) 366-7003.

Closing Date

The closing date is extended to July 31, 1992.

Issued in Washington, DC., May 26, 1992.

Belinda R. Zamer,

Deputy Director, Office of Training and Higher Education.

[FR Doc. 92-13070 Filed 6-3-92; 8:45 am]

BILLING CODE 4910-13-M

Passenger Facility Charge (PFC); Allentown-Bethlehem-Easton International Airport, PA

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of Intent to Rule on Application.

SUMMARY: The FAA proposes to rule and invites public comment on the application to impose a PFC at Allentown-Bethlehem-Easton International Airport under the provisions of the Aviation Safety and Capacity Expansion Act of 1990 (Title IX of the Omnibus Budget Reconciliation Act of 1990) (Pub. L. 101-508) and part 158 of the Federal Aviation Regulations (14 CFR part 158).

DATES: Comments must be received on or before July 6, 1992.

ADDRESSES: Comments on this application may be mailed or delivered in triplicate to the FAA at the following address: Harrisburg Airports District Office, 3911 Hartzdale Dr., suite 1, Camp Hill, PA 17011.

In addition, one copy of any comments submitted to the FAA must be mailed or delivered to Raymond D. Anderson, A.A.E., Director of Finance of the Lehigh-Northampton Airport Authority at the following address: 3311 Airport Road, Allentown, PA 18103.

Air carriers and foreign air carriers may submit copies of written comment

previously provided to the Lehigh-Northampton Airport Authority under § 158.23 of part 158.

FOR FURTHER INFORMATION CONTACT: L.W. Walsh, Manager Harrisburg Airports District Office, 3911 Hartzdale Dr., suite 1, Camp Hill, PA 17011. 717-782-4548. The application may be reviewed in person at this same location.

SUPPLEMENTARY INFORMATION: The FAA proposes to rule and invites public comment on the application to impose a PFC at Allentown-Bethlehem-Easton International Airport under the provisions of the Aviation Safety and Capacity Expansion Act of 1990 (Title IX of the Omnibus Budget Reconciliation Act of 1990) (Pub. L. 101-508) and part 158 of the Federal Aviation Regulations (14 CFR part 158).

On May 19, 1992, the FAA determined that the application to impose a PFC submitted by Lehigh-Northampton Airport Authority was substantially complete within the requirements of § 158.25 of part 158. The FAA will approve or disapprove the application, in whole or in part, no later than August 28, 1992.

The following is a brief overview of the application.

Level of the proposed PFC: \$3.00.
Proposed charge effective date: October 1, 1992.

Proposed charge expiration date: March 31, 1995.

Total estimated PFC revenue: \$3,778,111.

Brief description of proposed project(s):

- Preliminary Design of Passenger Terminal Building.
- Design of Passenger Terminal Building.
- Expand Passenger Terminal Building.

Class or classes of air carriers which the public agency has requested not be required to collect PFCs: Air-Taxi/Commercial operators filing FAA Form 1800-31.

Any person may inspect the application in person at the FAA office listed above under "FOR FURTHER INFORMATION CONTACT" and at the FAA regional Airports office located at: Federal Aviation Administration, Fitzgerald Federal Building, JFK International Airport, Jamaica, NY 11430.

In addition, any person may, upon request, inspect the application, notice and other documents germane to the application in person at the Lehigh-Northampton Airport Authority.

Issued in Jamaica, NY on May 26, 1992.

Peter A. Nelson,

Assistant Manager, Airports Division Eastern Region.

[FR Doc. 92-13071 Filed 6-3-92; 8:45 am]

BILLING CODE 4910-13-M

Passenger Facility Charge (PFC); University Park Airport, State College, PA

AGENCY: Federal Aviation Administration (FAA) DOT.

ACTION: Notice of Intent to Rule on Application.

SUMMARY: The FAA proposes to rule and invites public comment on the application to impose and use the revenue from a PFC at University Park Airport under the provisions of the Aviation Safety and Capacity Expansion Act of 1990 (Title IX of the Omnibus Budget Reconciliation Act of 1990) (Pub. L. 101-508) and part 158 of the Federal Aviation Regulations (14 CFR part 158).

DATES: Comments must be received on or before July 6, 1992.

ADDRESSES: Comments on this application may be mailed or delivered in triplicate to the FAA at the following address: Harrisburg Airports District Office, 3911 Hartzdale Dr., suite 1, Camp Hill, PA 17011.

In addition, one copy of any comments submitted to the FAA must be mailed or delivered to William R. Stacey, Management Specialist of the Pennsylvania State University at the following address: room 304 Old Main, University Park, PA 16802.

Air carriers and foreign air carriers may submit copies of written comments previously provided to the Pennsylvania State University under § 158.23 of part 158.

FOR FURTHER INFORMATION CONTACT: L.W. Walsh, Manager Harrisburg Airports District Office, 3911 Hartzdale Dr., suite 1, Camp Hill, PA 17011. 717-782-4548. The application may be reviewed in person at this same location.

SUPPLEMENTARY INFORMATION: The FAA proposes to rule and invites public comment on the application to impose and use the revenue from a PFC at University Park Airport under the provisions of the Aviation Safety and Capacity Expansion Act of 1990 (Title IX of the Omnibus Budget Reconciliation Act of 1990) (Pub. L. 101-508) and part 158 of the Federal Aviation Regulations (14 CFR part 158).

On May 15, 1992, the FAA determined that the application to impose and use the revenue from a PFC submitted by

Pennsylvania State University was substantially complete within the requirements of § 158.25 of part 158. The FAA will approve or disapprove the application, in whole or in part, no later than August 28, 1992.

The following is a brief overview of the application.

Level of the proposed PFC: \$3.00.

Proposed charge effective date: May 1, 1992.

Proposed charge expiration date: April 30, 2004.

Total estimated PFC revenue: \$5,058,723.

Brief description of proposed project(s):

- Terminal Apron expansion.
- Terminal expansion-phase I.
- Terminal expansion-phase II.
- Land acquisition.
- Upgrade & Renovate Taxiway B.
- Storm Water Management.
- Runway extension.
- Signage update.
- Emergency Generator.
- Obstruction removal.
- GA ramp rehabilitation.
- Runway Friction Tester.
- Runway Condition Sensors.
- Maintenance Building & Grit storage.
- Snow Removal equipment.
- ARFF Vehicle.
- Expand Taxiway B.
- Recondition existing Broom.
- Master Plan Update.
- Security & Access Control improvement.
- AWOS IV.
- Land Acquisition.
- Snow Removal Equipment—blower.
- Renovate Runway Lighting.
- Terminal Building Expansion.

Class or classes of air carriers which the public agency has requested not be required to collect PFCs: On demand Air-Taxi operators and Charter Carriers.

Any person may inspect the application in person at the FAA office listed above under "FOR FURTHER INFORMATION CONTACT" and at the FAA regional Airports office located at: Federal Aviation Administration, Fitzgerald Federal Building, JFK International Airport, Jamaica, NY 11430.

In addition, any person may, upon request, inspect the application, notice and other documents germane to the application in person at the Pennsylvania State University.

Issued in Jamaica, NY on May 26, 1992.

Peter A. Nelson,

Assistant Manager, Airports Division Eastern Region.

[FR Doc. 92-13073 Filed 6-3-92; 8:45 am]

BILLING CODE 4910-13-M

**Passenger Facility Charge (PFC);
Morgantown Municipal Airport,
Morgantown, WV**

AGENCY: Federal Aviation
Administration (FAA), DOT.

ACTION: Notice of Intent to Rule on
Application.

SUMMARY: The FAA proposes to rule and invites public comment on the application to impose and use the revenue from a PFC at Morgantown Municipal Airport under the provisions of the Aviation Safety and Capacity Expansion Act of 1990 (Title IX of the Omnibus Budget Reconciliation Act of 1990) (Public Law 101-508) and Part 158 of the Federal Aviation Regulations (14 CFR Part 158).

DATES: Comments must be received on or before July 6, 1992.

ADDRESSES: Comments on this application may be mailed or delivered in triplicate to the FAA at the following address: Beckley Airports Field Office, 469 Airport Circle, room 101, Beaver, West Virginia 25813.

In addition, one copy of any comments submitted to the FAA must be mailed or delivered to Robert L. Bryant, Airport Manager of the City of Morgantown, West Virginia at the following address: 389 Spruce Street, Morgantown, West Virginia, 26505.

Air carriers and foreign air carriers may submit copies of written comments previously provided to the City of Morgantown under § 158.23 of part 158.

FOR FURTHER INFORMATION CONTACT: Mr. Joseph Scheff, Manager Beckley Airports Field Office, 469 Airport Circle, room 101 Beaver, West Virginia 25813, (304) 252-6216. The application may be reviewed in person at this same location.

SUPPLEMENTARY INFORMATION: The FAA proposes to rule and invites public comment on the application to impose and use the revenue from a PFC at Morgantown Municipal Airport under the provisions of the Aviation Safety and Capacity Expansion Act of 1990 (Title IX of the Omnibus Budget Reconciliation Act of 1990) (Pub. L. 101-508) and part 158 of the Federal Aviation Regulations (14 CFR part 158).

On May 8, 1992, the FAA determined that the application to impose and use the revenue from a PFC submitted by the City of Morgantown was substantially complete within the requirements of § 158.25 of part 158. The FAA will approve or disapprove the application, in whole or in part, no later than September 4, 1992.

The following is a brief overview of the application.

Level of the proposed PFC: \$3.00.

Proposed charge effective date: October 1, 1992.

Proposed charge expiration date: October 31, 1994.

Total estimated PFC revenue: \$100,000.

Brief description of proposed project(s):

- Airfield Lighting and Guidance signs.
- Overlay T/W C, G.A. Apron and Air Carrier Apron.
- Construction and Lighting of T/W parallel to R/W 5-23.
- Construction of ARFF/Snow Removal Building.
- Purchase ARFF Equipment.

Class or classes of air carriers which the public agency has requested not be required to collect PCFs: None.

Any person may inspect the application in person at the FAA office listed above under "FOR FURTHER INFORMATION CONTACT" and at the FAA regional Airports office located at: Federal Aviation Administration, Fitzgerald Federal Building—AEA-600, JFK International Airport, Jamaica, New York 11430.

In addition, any person may, upon request, inspect the application, notice and other documents germane to the application in person at the City of Morgantown, West Virginia.

Issued in Jamaica, New York on May 28, 1992.

Peter A. Nelson,

Assistant Manager, Airports Division Eastern Region.

[FR Doc. 92-13072 Filed 6-3-92; 8:45 am]

BILLING CODE 4910-13-M

DEPARTMENT OF THE TREASURY

[Number: 150-19]

Delegation—Issuance of Immunity Orders

Date: May 28, 1992.

1. By virtue of the authority vested in the Secretary of the Treasury by sections 7802 and 7803 of the Internal Revenue Code of 1986, and by 31 U.S.C. 321(b), there is hereby delegated to the Commissioner of Internal Revenue, the function under Title II of the Organized Crime Control Act of 1970 (18 U.S.C. 6001, *et seq.*; 84 Stat. 926), with the approval of the Attorney General, to make determinations and to issue the orders to compel the testimony under a grant of immunity of any individual who has been or may be called to testify or provide information at any proceeding before the Internal Revenue Service which such individual refuses to give or provide on the basis of the individual's privilege against self-incrimination.

2. The authority herein delegated to the Commissioner of Internal Revenue may be redelegated to the Deputy Commissioner, the Assistant Commissioner (Criminal Investigation) and the Chief Inspector.

3. This Order supersedes Treasury Order 150-19, "Delegation—Issuance of Immunity Orders," dated November 29, 1977.

Nicholas F. Brady,

Secretary of the Treasury.

[FR Doc. 92-13059 Filed 6-3-92; 8:45 am]

BILLING CODE 4810-25-M

DEPARTMENT OF VETERANS AFFAIRS

Information Collection Under OMB Review

AGENCY: Department of Veterans Affairs.

ACTION: Notice.

The Department of Veterans Affairs has submitted to OMB the following proposal for the collection of information under the provisions of the Paperwork Reduction Act (44 U.S.C. chapter 35). This document lists the following information: (1) The title of the information collection, and the Department form number(s), if applicable; (2) a description of the need and its use; (3) who will be required or asked to respond; (4) an estimate of the total annual reporting hours, and recordkeeping burden, if applicable; (5) the estimated average burden hours per respondent; (6) the frequency of response; and (7) an estimated number of respondents.

ADDRESSES: Copies of the proposed information collection and supporting documents may be obtained from Janet G. Byers, Veterans Benefits Administration (20A5), Department of Veterans Affairs, 810 Vermont Avenue, NW., Washington, DC 20420 (202) 233-3021.

Comments and questions about the items on the list should be directed to VA's OMB Desk Officer, Joseph Lackey, NEOB, room 3002, Washington, DC 20503, (202) 395-7316. Do not send requests for benefits to this address.

DATES: Comments on the information collection should be directed to the OMB Desk Officer on or before July 6, 1992.

DATED: May 27, 1992.

By direction of the Secretary.

Frank E. Lalley,

Associate Deputy Assistant Secretary for Information Resources Policies and Oversight.

Extension

1. Supplement to VA Forms 21-528, 21-534, and 21-535 (For Philippine Claims), VA Form 21-4169.
2. The information is used by VA regional office in Manila to determine whether eligibility for VA benefits can be established based on service in the Commonwealth Army of the Philippines or recognized guerrilla organization.
3. Individuals or households.
4. 1,000 hours.
5. 1 hour.
6. On occasion.
7. 1,000 respondents.

[FR Doc. 92-13025 Filed 6-3-92; 8:45 am]

BILLING CODE 8320-01-M

Information Collection Under OMB Review

AGENCY: Department of Veterans Affairs.

ACTION: Notice.

The Department of Veterans Affairs has submitted to OMB the following proposal for the collection of information under the provisions of the Paperwork Reduction Act (44 U.S.C. chapter 35). This document lists the following information: (1) The title of the information collection, and the Department form number(s), if applicable; (2) a description of the need and its use; (3) who will be required or asked to respond; (4) an estimate of the total annual reporting hours, and recordkeeping burden, applicable; (5) the estimated average burden hours per respondent; (6) the frequency of response; and (7) an estimated number of respondents.

ADDRESSES: Copies of the proposed information collection and supporting documents may be obtained from Janet G. Byers, Veterans Benefits Administration (20A5), Department of Veterans Affairs, 810 Vermont Avenue, NW, Washington, DC 20420 (202) 233-3021.

Comments and questions about the items on the list should be directed to VA's OMB Desk Officer, Joseph Lackey, NEOB, room 3002, Washington, DC 20503, (203) 395-7316. Do not send requests for benefits to this address.

DATES: Comments on the following collection should be direct to the OMB Desk Officer on or before July 6, 1992.

Dated: May 27, 1992.

By direction of the Secretary:

Frank E. Lalley,

Associate Deputy Assistant Secretary for Information Resources Policies and Oversight.

Reinstatement

1. Certificate of Balance on Deposit, VA Form 27-4718(a).
2. This form is completed by VA fiduciaries, as required by State courts and/or Federal status, to lessen the vulnerability of Federal funds to fraud, waste, and abuse.
3. Individuals or households; State or local governments; Federal agencies or employees; Non-profit institutions.
4. 1,500 hours.
5. 3 minutes.
6. On occasion; Annually; Biennially; Triennially.
7. 30,000 respondents.

[FR Doc. 92-13026 Filed 6-3-92; 8:45 am]

BILLING CODE 8320-01-M

Information Collection Under OMB Review

AGENCY: Department of Veterans Affairs.

ACTION: Notice.

The Department of Veterans Affairs has submitted to OMB the following proposal for the collection of information under the provisions of the Paperwork Reduction Act (44 U.S.C. chapter 35). This document lists the following information: (1) The title of the information collection, and the Department form number(s), if applicable; (2) a description of the need and its use; (3) who will be required or asked to respond; (4) an estimate of the total annual reporting hours, and recordkeeping burden, if applicable; (5) the estimated average burden hours per respondent; (6) the frequency of response; and (7) an estimated number of respondents.

ADDRESSES: Copies of the proposed information collection and supporting documents may be obtained from Janet G. Byers, Veterans Benefits Administration (20A5), Department of Veterans Affairs, 810 Vermont Avenue, NW., Washington, DC 20420 (202) 233-3021.

Comments and questions about the items on the list should be directed to VA's OMB Desk Officer, Joseph Lackey, NEOB, room 3002, Washington, DC 20503, (202) 395-7316. Do not send requests for benefits to this address.

DATES: Comments on the information collection should be directed to the OMB Desk Officer on or before July 6, 1992.

Dated: May 27, 1992.

By direction of the Secretary.

Frank E. Lalley,

Associate Deputy Assistant Secretary for Information Resources Policies and Oversight.

Reinstatement

1. Other On-The-Job Training and Apprenticeship Training Agreement and Standards, VA Form 22-8864, and Employer's Application to Provide Job Training, VA Form 22-8865.
2. The information is collected from trainees and employers to ensure that apprenticeship and on-the-job training programs and agreements meet the statutory requirement for approval.
3. State or local governments; Farms; Businesses or other for-profit; Federal agencies or employees; Non-profit institutions; Small businesses or organizations.
4. 3,750 hours.
5. 50 minutes.
6. On occasion.
7. 4,500 respondents.

[FR Doc. 92-13027 Filed 6-3-92; 8:45 am]

BILLING CODE 8320-01-M

Information Collection Under OMB Review

AGENCY: Department of Veterans Affairs.

ACTION: Notice.

The Department of Veterans Affairs has submitted to OMB the following proposal for the collection of information under the provisions of the Paperwork Reduction Act (44 U.S.C. chapter 35). This document lists the following information: (1) The title of the information collection, and the Department form number(s), if applicable; (2) a description of the need and its use; (3) who will be required or asked to respond; (4) an estimate of the total annual reporting hours, and recordkeeping burden, if applicable; (5) the estimated average burden hours per respondent; (6) the frequency of response; and (7) an estimated number of respondents.

ADDRESSES: Copies of the proposed information collection and supporting documents may be obtained from Janet G. Byers, Veterans Benefits Administration (20A5), Department of Veterans Affairs, 810 Vermont Avenue, NW., Washington, DC 20420 (202) 233-3021.

Comments and questions about the items on the list should be directed to VA's OMB Desk Officer, Joseph Lackey, NEOB, room 3002, Washington, DC

20503, (202) 395-7316. Do not send requests for benefits to this address.
DATES: Comments on the information collection should be directed to the OMB Desk Officer on or before July 6, 1992.

Dated: May 26, 1992.

By directions of the Secretary.

Frank E. Lalley,

Associate Deputy Assistant Secretary for Information, Resources Policies and Oversight.

New Collection

1. Customer Based Measures Telephone Survey.

2. VA seeks to improve the quality, timeliness, and effectiveness of services to veterans and their beneficiaries. The information will be used to incorporate the veterans'/beneficiaries' perspective into plans for service delivery improvements, provide a basis on which to establish customer defined indicators, and provide blueprint for planning and resource allocation.

3. Individuals or households.

4. 806 hours.

5. 14 minutes.

6. Annually.

7. 3,456 respondents.

[FR Doc. 92-13031 Filed 6-3-92; 8:45 am]

BILLING CODE 8320-01-M

Information Collection Under OMB Review

AGENCY: Department of Veterans Affairs.

ACTION: Notice.

The Department of Veterans Affairs has submitted to OMB the following proposal for the collection of information under the provisions of the Paperwork Reduction Act (44 U.S.C. chapter 35). This document lists the following information: (1) The title of the information collection, and the Department form number(s), if applicable; (2) a description of the need and its use; (3) who will be required or asked to respond; (4) an estimate of the total annual reporting hours, and recordkeeping burden, if applicable; (5) the estimated average burden hours per respondent; (6) the frequency of response; and (7) an estimated number of respondents.

ADDRESSES: Copies of the proposed information collection and supporting documents may be obtained from Janet G. Byers, Veterans Benefits Administration (20A5), Department of Veterans Affairs, 810 Vermont Avenue, NW., Washington, DC 20420 (202) 233-3021.

Comments and questions about the items on the list should be directed to VA's OMB Desk Officer, Joseph Lackey, NEOB, room 3002, Washington, DC 20503, (202) 395-7316. Do not send requests for benefits to this address.

DATES: Comments on the information collection should be directed to the OMB Desk Officer on or before July 6, 1992.

Dated: May 27, 1992.

By direction of the Secretary.

Frank E. Lalley,

Associate Deputy Assistant Secretary for Information Resources Policies and Oversight.

Extension

1. Mortgage Loan Information, VA Form 26-8982.

2. This information card will be used to collect social security numbers as part of the accounting information required by credit reporting agencies on delinquent borrowers.

3. Individuals or households.

4. 829 hours.

5. 5 minutes.

6. On occasion.

7. 9,950 respondents.

[FR Doc. 92-13030 Filed 6-3-92; 8:45 am]

BILLING CODE 8320-01-M

Information Collection Under OMB Review

AGENCY: Department of Veterans Affairs.

ACTION: Notice.

The Department of Veterans Affairs has submitted to OMB the following proposal for the collection of information under the provisions of the Paperwork Reduction Act (44 U.S.C. chapter 35). This document lists the following information: (1) The title of the information collection, and the Department form number(s), if applicable; (2) a description of the need and its use; (3) who will be required or asked to respond; (4) an estimate of the total annual reporting hours, and recordkeeping burden, if applicable; (5) the estimated average burden hours per respondent; (6) the frequency of response; and (7) an estimated number of respondents.

ADDRESSES: Copies of the proposed information collection and supporting documents may be obtained from Janet G. Byers, Veterans Benefits Administration (20A5), Department of Veterans Affairs, 810 Vermont Avenue, NW., Washington, DC 20420 (202) 233-3021.

Comments and questions about the items on the list should be directed to

VA's OMB Desk Officer, Joseph Lackey, NEOB, room 3002, Washington, DC 20503, (202) 395-7316. Do not send requests for benefits to this address.

DATES: Comments on the information collection should be directed to the OMB Desk Officer on or before July 6, 1992.

Dated: May 27, 1992.

By direction of the Secretary.

Frank E. Lalley,

Associate Deputy Assistant Secretary for Information Resources Policies and Oversight.

Reinstatement

1. Application for Service-Disabled Insurance, VA Form 29-4364 and VA Form 29-4364-1.

2. The forms are used by veterans to apply for Service-Disabled Veterans Insurance, to designate a beneficiary and to select an optional settlement.

3. Individuals or households.

4. 2,833 hours.

5. 40 minutes.

6. On occasion.

7. 4,250 respondents.

[FR Doc. 92-13029 Filed 6-3-92; 8:45 am]

BILLING CODE 8320-01-M

Information Collection Under OMB Review

AGENCY: Department of Veterans Affairs.

ACTION: Notice.

The Department of Veterans Affairs has submitted to OMB the following proposal for the collection of information under the provisions of the Paperwork Reduction Act (44 U.S.C. chapter 35). This document lists the following information: (1) The title of the information collection, and the Department form number(s), if applicable; (2) a description of the need and its use; (3) who will be required or asked to respond; (4) an estimate of the total annual reporting hours, and recordkeeping burden, if applicable; (5) the estimated average burden hours per respondent; (6) the frequency of response; and (7) an estimated number of respondents.

ADDRESSES: Copies of the proposed information collection and supporting documents may be obtained from Janet G. Byers, Veterans Benefits Administration (20A5), Department of Veterans Affairs, 810 Vermont Avenue, NW., Washington, DC 20420 (202) 233-3021.

Comments and questions about the items on the list should be directed to

VA's OMB Desk Officer, Joseph Lackey, NEOB, room 3002, Washington, DC 20503, (202) 395-7316. Do not send requests for benefits to this address.

DATES: Comments on the information collection should be directed to the OMB Desk Officer on or before July 6, 1992.

Dated: May 27, 1992.

By direction of the Secretary.

Frank E. Lalley,

Associate Deputy, Assistant Secretary for Information Resources Policies and Oversight.

Reinstatement

1. Offer to Purchase and Contract of Sale, VA Form 26-6705, and Credit Statement of Prospective Purchaser, VA Form 26-6705b.

2. VA Form 26-6705 serves as an offer to purchase and contract of sale for submitted purchase offers to VA on properties acquired through operation of the guaranteed and direct loan programs. VA Form 26-6705b is used to

collect credit and income information necessary to determine whether an applicant qualifies to purchase a VA-owned property.

3. Individuals or households.
4. 38,547 hours.
5. 14 minutes.
6. On occasion.
7. 165,200 respondents.

FR Doc. 92-13028 Filed 6-3-92; 8:45 am]

BILLING CODE 8320-01-M

The Child Care Development of the VAMC Washington, DC; Designation

AGENCY: Department of Veterans Affairs.

ACTION: Notice of designation.

SUMMARY: The Secretary of the Department of Veterans Affairs is designating the Washington, DC VA Medical Center as a site that will be subject to child care development under the terms of an enhanced-use lease. The

Department intends to enter into a long-term lease of real property and facilities with the developer who provides the Department with the best quality care at the greatest economic advantage.

FOR FURTHER INFORMATION CONTACT:

Julia Reyes, Office of the Assistant Secretary for Acquisition and Facilities (005), 810 Vermont Ave., NW., Washington, DC 20420, 202-535-8555.

SUPPLEMENTARY INFORMATION: 38 U.S.C. 8161 et seq. specifically provides that the Secretary may enter into an enhanced-use lease with a private developer. This developer will provide services, revenue, or both, to the Department. The child care center will be economically self-sustaining and be compatible with the existing residential neighborhood.

Approved: May 26, 1992.

Edward J. Derwinski,

Secretary of Veterans Affairs.

[FR Doc. 92-13023 Filed 6-3-92; 8:45 am]

BILLING CODE 8320-01-M

Sunshine Act Meetings

Federal Register

Vol. 57, No. 108

Thursday, June 4, 1992

This section of the FEDERAL REGISTER contains notices of meetings published under the "Government in the Sunshine Act" (Pub. L. 94-409) 5 U.S.C. 552b(e)(3).

COMMODITY FUTURES TRADING COMMISSION

TIME AND DATE: 11:00 a.m., Friday, June 5, 1992.

PLACE: 2033 K St., N.W., Washington, D.C., 8th Floor Hearing Room.

STATUS: Closed.

MATTERS TO BE CONSIDERED:

Surveillance Matters

CONTACT PERSON FOR MORE

INFORMATION: Jean A. Webb, 254-6314.

Jean A. Webb,

Secretary of the Commission.

[FR Doc. 92-13254 Filed 6-2-92; 2:44 pm]

BILLING CODE 6351-01-M

COMMODITY FUTURES TRADING COMMISSION

TIME AND DATE: 10:00 a.m., Tuesday, June 9, 1992.

PLACE: 2033 K St., N.W., Washington, D.C., Lower Lobby Hearing Room.

STATUS: Open.

MATTERS TO BE CONSIDERED:

Application for the Chicago Mercantile Exchange for contract designation in Goldman Sachs Commodity Index futures and options.

CONTACT PERSON FOR MORE

INFORMATION: Jean W. Webb, 254-6314.

Jean A. Webb,

Secretary of the Commission.

[FR Doc. 92-13255 Filed 6-2-92; 2:44 pm]

BILLING CODE 6351-01-M

COMMODITY FUTURES TRADING COMMISSION

TIME AND DATE: 11:00 a.m., Friday, June 12, 1992.

PLACE: 2033 K St., N.W., Washington, D.C., 8th Floor Hearing Room.

STATUS: Closed.

MATTERS TO BE CONSIDERED:

Surveillance Matters

CONTACT PERSON FOR MORE

INFORMATION: Jean A. Webb, 254-6314.

Jean A. Webb,

Secretary of the Commission.

[FR Doc. 92-13256 Filed 6-2-92; 2:44 am]

BILLING CODE 6351-01-M

COMMODITY FUTURES TRADING COMMISSION

TIME AND DATE: 11:00 a.m., Friday, June 19, 1992.

PLACE: 2033 K St., N.W., Washington, D.C., 8th Floor Hearing Room.

STATUS: Closed.

MATTERS TO BE CONSIDERED:

Surveillance Matters

CONTACT PERSON FOR MORE

INFORMATION: Jean A. Webb, 254-6314.

Jean A. Webb,

Secretary of the Commission.

[FR Doc. 92-13257 Filed 6-2-92; 2:44 pm]

BILLING CODE 6351-01-M

COMMODITY FUTURES TRADING COMMISSION

TIME AND DATE: 11:00 a.m., Friday, June 26, 1992.

PLACE: 2033 K St., N.W., Washington, D.C., 8th Floor Hearing Room.

STATUS: Closed.

MATTERS TO BE CONSIDERED:

Surveillance Matters

CONTACT PERSON FOR MORE

INFORMATION: Jean A. Webb, 254-6314.

Jean A. Webb,

Secretary of the Commission.

[FR Doc. 92-13258 Filed 6-2-92; 2:44 pm]

BILLING CODE 6351-01-M

COMMODITY FUTURES TRADING COMMISSION

TIME AND DATE: 10 a.m., Tuesday, June 30, 1992.

PLACE: 2033 K St., NW., Washington, DC, 8th Floor Conference Room.

STATUS: Closed.

MATTERS TO BE CONSIDERED:

Enforcement Matters

CONTACT PERSON FOR MORE

INFORMATION: Jean A. Webb, 254-6314.

Jean A. Webb,

Secretary of the Commission.

[FR Doc. 92-13259 Filed 6-2-92; 2:44 pm]

BILLING CODE 6351-01-M

FEDERAL ELECTION COMMISSION

"FEDERAL REGISTER" NUMBER: 92-12668.

PREVIOUSLY ANNOUNCED DATE AND TIME:

Thursday, June 4, 1992, 10:00 a.m.,

Meeting Open to the Public.

THE FOLLOWING ITEM WAS DELETED FROM THE AGENDA:

Advisory Opinion 1992-13: Mr. James M. Blackburn

DATE AND TIME: Tuesday, June 9, 1992, 10:00 A.M.

PLACE: 999 E Street, N.W., Washington, D.C.

STATUS: This meeting will be closed to the public.

ITEMS TO BE DISCUSSED:

Compliance matters pursuant to 2 U.S.C.

§ 437g.

Audits conducted pursuant to 2 U.S.C. § 437g, § 438(b), and Title 26, U.S.C.

Matters concerning participation in civil actions or proceedings or arbitration Internal personnel rules and procedures or matters affecting a particular employee

DATE AND TIME: Thursday, June 11, 1992, 10:00 a.m.

PLACE: 999 E Street, N.W., Washington, D.C. (Ninth Floor).

STATUS: This meeting will be open to the public.

ITEMS TO BE DISCUSSED:

Correction and Approval of Minutes

Title 26 Certification Matters

Final Repayment Determination—Kemp for President

Final Repayment Determination—Bush-Quayle '88

Status of Regulations Projects (continued from meeting of May 14, 1992)

Administrative Matters

PERSON TO CONTACT FOR INFORMATION:

Mr. Fred Eiland, Press Officer,
Telephone: (202) 219-4155.

Delores R. Harris,

Administrative Assistant.

[FR Doc. 92-13191 Filed 6-2-92; 10:52 am]

BILLING CODE 6715-01-M

POSTAL RATE COMMISSION

Amended Notice of Meeting

[BAC 7710-FW]

**"FEDERAL REGISTER" CITATION OF
PREVIOUS ANNOUNCEMENT:** Vol. 57,
p. 21700, May 21, 1992.

**PREVIOUSLY ANNOUNCED TIME AND DATE
OF THE MEETING:** 2:00 p.m., June 8, 1992.

CHANGES IN THE MEETING: 10:00 a.m.,
June 15, 1992.

CONTACT PERSON FOR MORE

INFORMATION: Charles L. Clapp,
Secretary, Postal Rate Commission,
Room 300, 1333 H Street, NW.,

Washington, DC 20268-0001, Telephone
(202) 789-6840.

Charles L. Clapp,

Secretary.

[FR Doc. 92-13221 Filed 6-2-92; 8:45 am]

BILLING CODE 7715-01-M

federal register

Thursday
June 4, 1992

Part II

Department of Health and Human Services

Health Care Financing Administration

**42 CFR Parts 412 and 413
Medicare Program; Changes to the
Hospital Inpatient Prospective Payment
Systems and Fiscal Year 1993 Rates;
Proposed Rule**

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 412 and 413

[BPD-756-P]

RIN 0938-AF79

Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 1993 Rates

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Proposed rule.

SUMMARY: We are proposing to revise the Medicare hospital inpatient prospective payment systems for operating costs and capital-related costs to implement necessary changes arising from our continuing experience with the system. In addition, in the addendum to this proposed rule, we are describing changes in the amounts and factors necessary to determine prospective payment rates for Medicare hospital inpatient services for operating costs and capital-related costs. These changes would be applicable to discharges occurring on or after October 1, 1992. We are also setting forth proposed rate-of-increase limits for hospitals and hospital units excluded from the prospective payment systems.

Finally, we are proposing changes and clarifications to the criteria and procedures concerning the reclassification of hospitals by the Medicare Geographic Classification Review Board. These changes result from public comment and our analysis of hospital reclassifications for Federal fiscal year (FY) 1992. The changes would be effective for applications submitted by September 30, 1992 for geographic reclassifications to be implemented on October 1, 1993 (FY 1994).

DATES: Written comments will be considered if we receive them at the appropriate address, as provided below, no later than 5 p.m. on August 3, 1992.

ADDRESSES: Mail comments to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: BPD-756-P, P.O. Box 26676, Baltimore, Maryland 21207.

If you prefer, you may deliver your comments to one of the following addresses: Room 309-G, Hubert H. Humphrey Building, 200 Independence Ave., SW., Washington, D.C. 20201, or Room 132, East High Rise Building, 6325 Security Boulevard, Baltimore, Maryland 21207.

Due to staffing and resource limitations, we cannot accept audio, visual, or facsimile (FAX) copies of comments.

If comments concern information collection recordkeeping requirements, please address a copy of comments to: Office of Management and Budget, Office of Information and Regulatory Affairs, Room 3001, New Executive Office Building, Washington, DC 20503, Attention: Allison Herron Eyd.

In commenting, please refer to file code BPD-756-P. Comments received timely will be available for public inspection as they are received, generally beginning approximately three weeks after publication of a document, in room 309-G of the Department's offices at 200 Independence Ave., SW., Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: 202-245-7890).

To obtain data used in deriving the standardized amounts and DRG relative weights, see section IX.B of the preamble, Public Requests for Data.

Copies: To order copies of the Federal Register containing this document, send your request to: Government Printing Office, ATTN: New Order, P.O. Box 371954, Pittsburgh, PA 15250-7954.

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FOR FURTHER INFORMATION CONTACT: Barbara Wynn, (410) 966-4529.

SUPPLEMENTARY INFORMATION:

I. Background

A. Summary

Under section 1886(d) of the Social Security Act (the Act), a system of payment for the operating costs of acute hospital inpatient stays under Medicare Part A (Hospital Insurance) based on prospectively-set rates was established effective with hospital cost reporting periods beginning on or after October 1, 1983. Under this system, Medicare payment for hospital inpatient operating

costs is made at a predetermined, specific rate for each hospital discharge. All discharges are classified according to a list of diagnosis-related groups (DRGs). The regulations governing the hospital inpatient prospective payment system are located in 42 CFR part 412. On August 30, 1991, we published a final rule (56 FR 43196) to implement changes to the prospective payment system for hospital operating costs for Federal fiscal year (FY) 1992.

For cost reporting periods beginning before October 1, 1991, hospital inpatient operating costs were the only costs covered under the prospective payment system. Payment for capital-related costs had been made on a reasonable cost basis because, under sections 1886(a)(4) and (d)(1)(A) of the Act, those costs had been specifically excluded from the definition of inpatient operating costs. However, section 4006(b) of the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100-203) revised section 1886(g)(1) of the Act to require that, for hospitals paid under the prospective payment system for operating costs, capital-related costs would also be paid under a prospective payment system effective with cost reporting periods beginning on or after October 1, 1991.

Therefore, on August 30, 1991, we published an additional final rule (56 FR 43358) in which we revised the Medicare payment methodology for inpatient capital-related costs for hospitals paid under the prospective payment system for operating costs. As required by section 1886(g) of the Act, we replaced the reasonable cost-based payment methodology with a prospective payment methodology for hospital inpatient capital-related costs. Under the new methodology, effective for cost reporting periods beginning on or after October 1, 1991, a predetermined payment amount per discharge is made for Medicare inpatient capital-related costs.

We established the standard Federal rate for FY 1992 using the FY 1989 Medicare inpatient capital cost per discharge updated to FY 1992 by the estimated increase in Medicare capital costs per discharge. In addition, we established a 10-year transition period for hospitals to be paid for their capital-related costs under one of two different payment methods. Generally, hospitals with a hospital-specific rate below the Federal rate are paid based on a fully prospective payment methodology. Hospitals with a hospital-specific rate at or above the Federal rate are paid based on a hold-harmless method or 100 percent of the Federal rate, whichever

results in a higher payment. Beginning with hospital cost reporting periods beginning on or after October 1, 2001, all hospitals are paid the Federal rate except for certain new hospitals that have not completed their transition period. (See the August 30, 1991 final rule (56 FR 43358) for a complete discussion of the prospective payment system for hospital inpatient capital-related costs.)

Hospitals and hospital distinct-part units that are excluded from the prospective payment system under the regulations at part 412, subpart B continue to be paid for capital-related costs on a reasonable cost basis under the provisions of part 413, subpart G. Also, rural primary care hospitals are not currently subject to prospective payment rules as provided under section 1814(l) of the Act and the last sentence of section 1861(e) of the Act.

B. Major Contents of this Proposed Rule

In this proposed rule, we are setting forth proposed changes to the Medicare hospital inpatient prospective payment systems for both operating costs and capital-related costs. This proposed rule would be effective for discharges occurring on or after October 1, 1992. Following is a summary of the major changes that we are proposing to make:

1. Changes to the DRG Classification and Weighting Factors

As required by section 1886(d)(4)(C) of the Act, we must adjust the DRG classifications and weighting factors at least annually. Our proposed changes for FY 1993 are set forth in section II of this preamble.

2. Changes to the Hospital Wage Index

In section III of this preamble, we discuss revisions to the wage index and, in particular, the revisions necessary because of hospital geographic reclassifications.

3. Changes Concerning Reclassifications by the Medicare Geographic Classification Review Board

In section IV of this preamble, we discuss the criteria and procedures for hospital reclassifications by the Medicare Geographic Classification Review Board and set forth proposed changes concerning the following:

- General guidelines—reclassifications for individual hospitals
- Reclassification to a single geographic area.
- Individual urban hospital reclassification to a rural area.
- Special access rule for rural referral center and sole community hospitals seeking reclassification.

—Guidelines for a hospital requesting reclassification for wage index purposes.

—Application of numeric standards:

- Implementation of FY 1994 hospital reclassifications.

—Appropriate wage data.

—Revised labor market areas.

- Administrative and procedural guidelines.

—Withdrawing an application.

—Reopenings.

4. Other Changes to the Prospective Payment System for Inpatient Operating Costs

In section V of this preamble, we discuss several provisions of the regulations in 42 CFR parts 412 and 413 and set forth certain proposed changes concerning the following:

- Outlier payments.
- Rural referral center criteria.
- Direct graduate medical education payments.

5. Changes to Capital Prospective Payment System Rules

In section VI of this preamble, we discuss several provisions of the regulations at 42 CFR part 412, subpart M, and set forth certain proposed changes concerning the following:

- Payments to new hospitals.
- Portion of hospital assets put in patient care service after December 31, 1990.
- Treatment of old capital costs when hospitals are leased after December 31, 1990.
- Obligated capital costs.
- Adjusting the hospital-specific rate—transfer-adjusted discharge and case-mix index for subsequent base periods.
- Redetermination of the hospital-specific rate.
- Effect of hospital mergers, consolidations or dissolution on the hospital-specific rate.
- Extraordinary circumstances exceptions payments.
- Minor technical corrections.

6. Changes for Hospitals Excluded from the Prospective Payment System

In section VII of this preamble, we discuss changes to the regulations at 42 CFR parts 412 and 413 for hospitals and units excluded under the prospective payment system. The proposed changes concern the following:

- Provisionally excluded hospitals and units.
- Definition of discharge for purposes of applying the rate-of-increase limits applicable to excluded hospitals and distinct part units.

• New hospital exemption applicable to excluded hospitals.

• Adjustments under the rate-of-increase ceiling.

7. Determining Prospective Payment Rates and Rate-of-Increase Limits

In the addendum to this proposed rule, we set forth proposed changes to the amounts and factors for determining the FY 1993 prospective payment rates for operating costs and capital-related costs. We are also proposing new target rate percentages for determining the rate-of-increase limits for cost reporting periods beginning in FY 1993 for hospitals and hospital units excluded from the prospective payment system.

8. Impact Analysis

In appendix A, we set forth an analysis of the impact that the proposed changes described in this rule would have on affected entities.

9. Capital Acquisition Model

Appendix B contains the technical appendix on the proposed FY 1993 capital acquisition model and budget neutrality adjustment.

10. Report to Congress on the Update Factor

Section 1886(e)(3)(B) of the Act requires that the Secretary report to Congress no later than March 1, 1992 on our initial estimate of an update factor for FY 1993 for both prospective payment hospitals and hospitals excluded from the prospective payment system. This report is included as appendix C to this proposed rule.

11. Proposed Recommendation of Update Factor

As required by sections 1886(e)(4) and (e)(5) of the Act, appendix D provides our recommendation of the appropriate percentage change for FY 1993 for the following:

- Large urban, other urban, and rural average standardized amounts (and hospital-specific rates applicable to sole community hospitals) for hospital inpatient services paid for under the prospective payment system for operating costs.
- Target rate-of-increase limits to the allowable operating costs of hospital inpatient services furnished by hospitals and hospital units excluded from the prospective payment system.

12. Discussion of Prospective Payment Assessment Commission Recommendations

The Prospective Payment Assessment Commission (ProPAC) is directed by the

provisions of sections 1886(e)(2) (A) of the Act to make recommendations on the appropriate percentage change factor to be used in updating the average-standardized amounts beginning with FY 1986 and thereafter. In addition, section 1886(e)(2)(B) of the Act, as added by section 4002(g) of the Omnibus Budget Reconciliation Act of 1990 (Pub. L. 101-508), directs ProPAC to make recommendations regarding changes in each of the Medicare payment policies under which payments to an institution are prospectively determined. In particular, the recommendations relating to the hospital inpatient prospective payment systems are to include recommendations concerning the number of DRGs used to classify patients, adjustments to the DRGs to reflect severity of illness, and changes in the methods under which hospitals are paid for capital-related costs. As set forth in section 1886(e)(3)(A) of the Act, the recommendations required of ProPAC under sections 1886(e)(2)(A) and (B) of the Act are to be reported to Congress not later than March 1 of each year.

We are printing ProPAC's March 1, 1992 report, which includes its recommendations, as appendix E of this document. The recommendations, and the actions we are proposing to take with regard to them (when an action is recommended), are discussed in detail in the appropriate sections of this preamble, the addendum, or the appendixes of this proposed rule. Those recommendations that are not specifically relevant to matters presented below are discussed in section VIII of this preamble. For a brief summary of the ProPAC recommendations, we refer the reader to pages 5 through 12 of the ProPAC report as set forth in appendix E of this proposed rule. ProPAC also produced technical appendixes in its March 1, 1992 report that provide background material and detailed analyses used in preparation of the ProPAC recommendations. For further information relating specifically to the ProPAC report or to obtain a copy of the technical appendixes, contact ProPAC at (202) 401-8986.

II. Proposed Changes to DRG Classifications and Weighting Factors

A. Background

Under the prospective payment system, we pay for inpatient hospital services on the basis of a rate per discharge that varies by the DRG to which a beneficiary's stay is assigned. The formula used to calculate payment for a specific case takes an individual

hospital's payment rate per case and multiplies it by the weight of the DRG to which the case is assigned. Each DRG weight represents the average resources required to care for cases in that particular DRG relative to the average resources used to treat cases in other DRGs.

Congress recognized that it would be necessary to recalculate the DRG relative weights periodically to account for changes in resource consumption. Accordingly, section 1886(d)(4)(C) of the Act requires that the Secretary adjust the DRG classifications and weighting factors annually. These adjustments are made to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources. The proposed changes to the DRG classification system and the proposed recalibration of the DRG weights for discharges occurring on or after October 1, 1992 are discussed below.

B. DRG Reclassification

1. General

Cases are classified into DRGs for payment under the prospective payment system based on the principal diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay, as well as age, sex, and discharge status of the patient.¹ The diagnosis and procedure information is reported by the hospital using codes from the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM). The intermediary enters the information into its claims system and subjects it to a series of automated screens called the Medicare Code Editor (MCE). These screens are designed to identify cases that require further review before classification into a DRG can be accomplished.

After screening through the MCE and any further development of the claims, cases are classified by the GROPER software program into the appropriate DRG. The GROPER program was developed as a means of classifying each case into a DRG on the basis of the diagnosis and procedure codes and demographic information (that is, sex, age, and discharge status). It is used both to classify past cases in order to measure relative hospital resource consumption to establish the DRG weights and to classify current cases for purposes of determining payment.

¹ Effective with discharges occurring on or after October 1, 1991, we allowed an expansion of the number of reported diagnosis and procedure codes from 5 to 9 and from 3 to 6, respectively. Hospitals are required to code at the new level effective with discharges occurring on or after April 1, 1992.

Currently, cases are assigned to one of 489 DRGs in 25 major diagnostic categories (MDCs). Most MDCs are based on a particular organ system of the body (for example, MDC 6, Diseases and Disorders of the Digestive System); however, some MDCs are not constructed on this basis since they involve multiple organ systems (for example, MDC 22, Burns).

In general, principal diagnosis determines MDC assignment. However, there are four DRGs to which cases are assigned on the basis of procedure codes rather than first assigning them to an MDC based on the principal diagnosis. These are the DRGs for liver and bone marrow transplant (DRGs 480 and 481, respectively) and the two DRGs for tracheostomies (DRGs 482 and 483). Cases are assigned to these DRGs before classification to an MDC.

Within most MDCs, cases are then divided into surgical DRGs (based on a surgical hierarchy that orders individual procedures or groups of procedures by resource intensity) and medical DRGs. Medical DRGs generally are differentiated on the basis of diagnosis and age. Some surgical and medical DRGs are further differentiated based on the presence or absence of complications or comorbidities (hereafter CC).

Generally, GROPER does not consider other procedures; that is, nonsurgical procedures or minor surgical procedures generally not performed in an operating room are not listed as operating room (OR) procedures in the GROPER decision tables. However, there are a few non-OR procedures that do affect DRG assignment for certain principal diagnoses, such as extracorporeal shock wave lithotripsy for patients with a principal diagnosis of urinary stones.

The changes we are proposing to make to the DRG classification system for FY 1993 are set forth below.

2. Reassignment of Certain Endoscopic Procedures (DRGs 76 and 77)

Currently, the only endoscopic procedure performed on the respiratory system that is considered an OR procedure is procedure code 33.27 (Closed endoscopic biopsy of lung). This procedure code is assigned to DRG 76 or 77 (Other Respiratory System OR Procedures)² if the patient's principal

² A single title combined with two DRG numbers is used to signify pairs. Generally, the first DRG is for cases with CC and the second is for cases without CC. If a third number is included, it represents cases of patients who are age 0-17. Occasionally, a pair of DRGs are split on age > 17 and age 0-17.

diagnosis is classified in MDC 4 (Diseases and Disorders of the Respiratory System). If procedure code 33.27 is performed in connection with a principal diagnosis assigned to another MDC, and no other procedure related to that diagnosis is performed, the case is assigned to DRG 468 (Extensive OR Procedure Unrelated to Principal Diagnosis).

Based on inquiries from the industry as well as our own concerns, we have reviewed the appropriate assignment of two other respiratory system endoscopic procedures: Endoscopic excision or destruction of lesion or tissue of lung (procedure code 32.28) and Closed [endoscopic] biopsy of bronchus (procedure code 33.24). Currently, performance of these non-OR procedures affects DRG assignment only in MDC 17 (Myeloproliferative Diseases and Disorders and Poorly Differentiated Neoplasms). For principal diagnoses that are assigned to that MDC, the performance of procedure codes 32.28 or 33.24 results in assignment to medical DRG 412 (History of Malignancy with Endoscopy). The preliminary information we received was that procedure codes 32.28 and 33.24 should be considered OR procedures and be assigned to MDC 4 because they are similar to procedure code 33.27 in terms of resource use and complexity.

Our analysis of the FY 1993 Medicare provider analysis and review file (MEDPAR) data demonstrated that, in the medical DRGs in MDC 4, the cases in which either procedure code 32.28 or 33.24 was performed had, on average, higher charges and lengths of stay than did the other cases assigned to these DRGs. This was particularly true for cases that included a CC. A comparison of the average charge and length of stay of medical cases with codes 32.28 and 33.24 with the average charge and length of stay of cases in DRGs 76 and 77 with procedure code 33.27 demonstrates that these cases are very similar in terms of resource use.

Based on these findings, we are proposing that endoscopic procedure codes 32.28 and 33.24 be designated as OR procedures and assigned to DRGs 76 and 77 in MDC 4. Because of this new designation, these procedures would be removed from medical DRG 412 in MDC 17. If procedure code 32.28 or 33.24 appears on a claim with a principal diagnosis in MDC 17, it would be assigned to surgical DRG 408 (Myeloproliferative Disorders or Poorly Differentiated Neoplasms with Other O.R. Procedure) as is procedure code 33.27.

In addition, based on our analysis of average charges, we are proposing that

procedure codes 32.28 and 33.24 be assigned to DRG 477 (Nonextensive OR Procedure Unrelated to Principal Diagnosis) when they are unrelated to the principal diagnosis and no OR procedure related to the principal diagnosis is performed. We note that procedure code 33.27 is assigned to DRG 468 (Extensive OR Procedure Unrelated to Principal Diagnosis).

3. Automatic Implantable Cardioverter Defibrillator (AICD) Procedures (DRG 120)

For several years, we have received a great deal of correspondence concerning the appropriate DRG assignment of certain procedures involving automatic implantable cardioverter defibrillators (AICDs). Currently, when a patient whose principal diagnosis is classified to MDC 5 (Diseases and Disorders of the Circulatory System) receives a total AICD system implant or replacement (procedure code 37.94), the case is assigned to DRG 104 or 105 (Cardiac Valve Procedures with or without Cardiac Catheterization).

However, if a procedure is performed that involves the implantation or replacement of only part of the AICD system (that is, replacement or implant of either the leads or pulse generator only), the case is assigned to DRG 120 (Other Circulatory System OR Procedures). The related procedure codes are the following: 37.95 (Implantation of automatic cardioverter/defibrillator lead(s) only), 37.96 (Implantation of automatic cardioverter/defibrillator pulse generator only), 37.97 (Replacement of cardioverter/defibrillator lead(s) only), and 37.98 (Replacement of automatic cardioverter/defibrillator pulse generator only). We note that if a case is coded with a pair of codes that indicates total implant (37.95 and 37.96) or total replacement (37.97 and 37.98), it groups to DRG 104 or 105.

The correspondence we have received has generally recommended that cases in which only part of an AICD system is implanted or replaced be reassigned from DRG 120 to a DRG that more accurately reflects the resources incurred in performing the procedure, preferably a DRG with a higher weight than that of DRG 120. This recommendation has been based on various studies commissioned by the manufacturer of the AICD device. These studies have concluded that the average standardized charges for implant or replacement of AICD leads or pulse generator only have been consistently understated in the MEDPAR file. For a detailed discussion of the previous years' comments and our responses on

this subject, see the final rules dated September 1, 1989 (54 FR 36465), September 4, 1990 (55 FR 36023), and August 30, 1991 (56 FR 43216).

In the August 30, 1991 final rule, we described the various measures we had taken in an attempt to improve the MEDPAR charge and coding data on AICD devices. We furnished information given to us by commenters about potential improper coding and billing to the Peer Review Organizations (PROs) for their review. In addition, we sent an instruction to our fiscal intermediaries (Transmittal No. 1525, May 1991) to return to the hospital for review any inpatient claim with procedure code 37.94, 37.95, 37.96, 37.97, or 37.98 for which total charges are less than \$17,000. (The manufacturer claimed that the device alone costs \$13,500 and the additional \$3,500 represents the average cost of a 4-day length of stay.) We also instructed the carriers to deny charges under Medicare Part 8 for any defibrillator implant furnished in support of surgery during an inpatient hospital stay (Transmittal No. 1393, May 1991). These charges are to be included on the inpatient bill and not billed separately. In the August 30, 1991 final rule, we stated that these changes should improve the AICD data in the FY 1991 MEDPAR file, and we would review those cases as a part of our FY 1993 DRG analysis (56 FR 43217).

Our analysis of the AICD cases in the FY 1991 MEDPAR data was based on 958 cases assigned to DRG 120 and 273 cases that were assigned to DRG 112 (Percutaneous Cardiovascular Procedures). (Cases that involve the implant or replacement of AICD lead or generator only group to DRG 112 when electrophysiologic (EP) studies (procedure code 37.26) are also performed.) Based on these cases, we found that the cases with AICD procedures that were classified in DRG 120 in FY 1991 had an average standardized charge of \$19,380. The cases that grouped to DRG 112 had an average standardized charge of \$32,626. Thus, the overall average standardized charge for these cases was \$22,317.

Since the average standardized charge for all cases in DRGs 112 and 120 in FY 1991 was only approximately \$14,000, we believe it is appropriate to propose a change in the classification of the AICD cases effective for FY 1993. Because it is generally not our policy to create single procedure DRGs, we are proposing to reassign AICD cases to an existing DRG. However, the current clinical composition and weights of the surgical DRGs in MDC 5 do not offer a perfect match for reclassification of the AICD

cases. After reviewing the current DRGs in terms of clinical coherence and similar resource use, we are proposing to reassign procedure codes 37.95, 37.96, 37.97, and 37.98, when they do not occur as pairs, to DRG 116 (Permanent Cardiac Implant without AMI, Heart Failure, or Shock). The average standardized charge of \$17,214 for DRG 116 is higher than that of both DRGs 112 and 120 and, from a clinical perspective, we believe that the surgical implant of an AICD device is similar to a pacemaker implant. We considered assigning these cases to both DRGs 115 (Permanent Cardiac Pacemaker Implant with AMI, Heart Failure or Shock) and 116, so that AICD implants would be assigned in the same way permanent cardiac pacemakers are (that is, depending on principal diagnosis). However, our review of cases in which an AICD device is replaced or implanted showed no cases in which AMI, heart failure, or shock is a principal diagnosis. Therefore, in any case, all the AICD cases would group to DRG 116.

We believe that the reassignment to DRG 116 would help improve the payment for the AICD cases and would not disrupt the current MDC 5 surgical classification. Since DRG 116 is higher in the surgical hierarchy than DRG 112, the AICD cases that currently group to DRG 112 would also be reassigned to DRG 116. The new title of DRG 116 would be "Other Permanent Cardiac Pacemaker Implant or AICD Lead or Generator Procedure."

4. Major Joint and Limb Reattachment Procedures of Lower Extremity (DRG 209)

As a part of the DRG changes set forth in the August 30, 1991 final rule, we revised the classification of cases assigned to DRG 209. Before October 1, 1991, DRG 209 was titled: "Major Joint and Limb Reattachment Procedures", and procedures of both the upper and lower extremity were assigned that DRG. Effective with discharges occurring on or after October 1, 1991, former DRG 209 was split into two DRGs: DRG 209 (Major Joint and Limb Reattachment Procedures of Lower Extremity) and DRG 491 (Major Joint and Limb Reattachment Procedures of Upper Extremity). (See 56 FR 43205.)

In the August 30, 1991 final rule, in response to a comment we received on the DRG 209 change, we stated that we would analyze the appropriate assignment of major limb reattachment procedures as part of our analysis of potential FY 1993 changes. The commenter suggested that major limb reattachment procedures be separated and assigned to a new DRG. The

commenter believes that these procedures are clinically different from and incur higher costs than major joint replacement procedures. The commenter also stated that limb reattachments are comparatively rare and are usually performed as emergency procedures rather than on an elective basis, as are major joint replacements.

We analyzed the FY 1991 MEDPAR data for limb reattachment cases and found that there were no major limb reattachment cases in the 10 percent sample of all Medicare cases that we use for analyzing possible classification changes. That is, in the 10 percent sample, there were no cases of limb reattachments (of either upper or lower extremities) found in any DRG, including DRG 209 and DRG 485 (Limb Reattachment, Hip and Femur Procedures for Multiple Significant Trauma). While these limb reattachment cases may be different clinically and in terms of resource consumption from the major joint replacement cases in DRG 209 and from the other cases in DRG 485, these cases appear to be especially rare in the Medicare population. Based on the lack of supporting data and the fact that few reattachment procedures are performed, we are not proposing any changes to the DRG assignment of major limb reattachment cases.

5. Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders (MDC 20)

In response to concerns that the alcohol/drug DRGs needed further refinement, alcohol/drug treatment hospitals and distinct part hospital units were excluded from the prospective payment system soon after its implementation. This exclusion was temporary until an adjustment to the DRG classification system would permit prospective payment to be made appropriately for alcohol and drug treatment services.

In 1986, in order to address previous data deficiencies and to ensure the most accurate analysis possible, a representative sampling of FY 1984 MDC 20 cases was analyzed using data abstracted from medical records. This study indicated that the use of CCs explained significant differences in resource use and improved overall homogeneity in the alcohol and drug DRG classification, particularly in DRGs 434 and 435. In addition, the effects of CCs explained more of the variation in resource utilization than did other variables studied, including the presence or absence of surgery. Therefore, the DRGs were restructured as follows:

DRG 433	Alcohol/drug abuse or dependence, left against medical advice.
DRG 434	Alcohol/drug abuse or dependence, detoxification or other symptomatic treatment, with CC.
DRG 435	Alcohol/drug abuse or dependence, detoxification or other symptomatic treatment, without CC.
DRG 436	Alcohol/drug dependence with rehabilitation therapy.
DRG 437	Alcohol/drug dependence, combined rehabilitation and detoxification therapy.

Based on this study, the exclusion of alcohol/drug treatment hospital and units from the prospective payment system was eliminated, and these hospitals and units were brought under the prospective payment system effective October 1, 1987 (FY 1988). (For a detailed discussion of this change, see the June 10, 1987 proposed rule (52 FR 22081), the September 1, 1987 final rule (52 FR 33036), and the September 1, 1987 final notice on DRG classification changes (52 FR 33143).)

Since that time, we have received inquiries about the absence of any surgical partitioning in MDC 20. In particular, comments we received in response to the June 3, 1991 proposed rule were concerned that the performance of a surgical procedure on patients admitted for treatment for alcohol/drug related conditions that classify to MDC 20 had no influence on the DRG assignment. In the August 30, 1991 final rule, in response to these comments, we stated our intention to examine this issue as a part of our analysis of potential FY 1993 DRG classification changes (56 FR 43203).

Our analysis of the FY 1991 MEDPAR data has revealed that the procedures reported for MDC 20 discharges were almost entirely therapeutic or diagnostic in nature. Only 1.5 percent of all procedures reported were operating room (OR) procedures. Since more than one OR procedure was often performed for a particular hospital stay, the total number of cases in MDC 20 that would result in a surgical DRG assignment is under 1 percent. We do not believe that this is a sufficient number of cases to create a surgical DRG in MDC 20. In addition, none of these OR procedures could be said to be related to the principal diagnosis that classified the case to MDC 20.

However, a review of the average charges for the surgical cases shows that these cases tend to be much more expensive than the medical cases that

group to that MDC. In fact, the average charge for a case with an OR procedure more closely resembles the average charge of those cases classified to DRGs 468 (Extensive OR Procedure Unrelated to Principal Diagnosis), 476 (Prostatic OR Procedure Unrelated to Principal Diagnosis), and 477 (Nonextensive OR Procedure Unrelated to Principal Diagnosis), depending on the assignment procedure. Therefore, to ensure equitable payment and to accommodate surgeries performed during alcohol/drug admissions, we are proposing that all cases classified in MDC 20 for which an OR procedure is performed would be assigned to DRG 468, 476, or 477 as appropriate, effective with discharges on or after October 1, 1992. DRGs 433 through 437 will otherwise remain as currently structured.

6. Surgical Hierarchies

Some inpatient stays entail multiple surgical procedures, each one of which, occurring by itself, could result in assignment of the case to a different DRG within the MDC to which the principal diagnosis is assigned. It is, therefore, necessary to have a decision rule by which these cases are assigned to a single DRG. The surgical hierarchy, an ordering of surgical classes from most to least resource intensive, performs that function. Its application ensures that cases involving multiple surgical procedures are assigned to the DRG associated with the most resource-intensive surgical class.

Because the relative resource intensity of surgical classes can shift as a function of DRG reclassification and recalibration, we reviewed the surgical hierarchy of each MDC, as we have for previous reclassifications, to determine if the ordering of classes coincided with the intensity of resource utilization, as measured by the same billing data used to compute the DRG relative weights.

A surgical class can be composed of a one or more DRGs. For example, in MDC 5, the surgical class "heart transplant" consists of a single DRG (DRG 103) and the class "coronary bypass" consists of two DRGs (DRGs 106 and 107). Consequently, in many cases, the surgical hierarchy has an impact on more than one DRG. The methodology for determining the most resource-intensive surgical class, therefore, involves weighting each DRG for frequency to determine the average resources for each surgical class. For example, assume surgical class A includes DRGs 1 and 2 and surgical class B includes DRGs 3, 4, and 5, and that the average charge of DRG 1 is higher than that of DRG 3, but the average charges of DRGs 4 and 5 are

higher than the average charge of DRG 2. To determine whether surgical class A should be higher or lower than surgical class B in the surgical hierarchy, we would weight the average charge of each DRG by frequency (that is, by the number of cases in the DRG) to determine average resource consumption for the surgical class. The surgical classes would then be ordered from the class with the highest average resource utilization to that with the lowest, with the exception of "other OR procedures" as discussed below.

This methodology may occasionally result in a case involving multiple procedures being assigned to the lower-weighted DRG (in the highest, most resource-intensive surgical class) of the available alternatives. However, given that the logic underlying the surgical hierarchy provides that the GROUPE searches for the procedure in the most resource-intensive surgical class, which may sometimes occur in cases involving multiple procedures, this result is unavoidable.

We would like to point out, notwithstanding the foregoing discussion, that there are a few instances where a surgical class with a lower average relative weight is ordered above a surgical class with a higher average relative weight. For example, the "other OR procedures" surgical class is uniformly ordered last in the surgical hierarchy of each MDC in which it occurs regardless of the fact that the weighting factor for the DRG or DRGs in that surgical class may be higher than that for other surgical classes in the MDC. The "other OR procedures" class is a group of procedures that are least likely to be related to the diagnoses in the MDC but are occasionally performed on patients with these diagnoses. Therefore, these procedures should only be considered if no other procedure more closely related to the diagnoses in the MDC has been performed.

A second example occurs when the difference between the average weights for two surgical classes is very small. We have found that small differences generally do not warrant reordering of the hierarchy since, by virtue of the hierarchy change, the weighting factors are likely to shift such that the higher-ordered surgical class has a lower average weight than the class ordered below it.

Based on the preliminary recalibration of the DRGs, we are proposing to modify the surgical hierarchy as set forth below. As we stated in the September 1, 1989 final rule (54 FR 36457), we are unable to test the effects of the proposed revisions to the surgical hierarchy and to reflect

these changes in the proposed relative weights due to the unavailability of revised GROUPE software at the time this proposed rule is prepared. Rather, we simulate most major classification changes to approximate the placement of cases under the proposed reclassification and then determine the average charge for each DRG. These average charges then serve as our best estimate of relative resource use for each surgical class. We test the proposed surgical hierarchy changes after the revised GROUPE is received and reflect the final changes in the DRG relative weights in the final rule. Further, as discussed below in section ILC of this preamble, we anticipate that the final recalibrated weights will be somewhat different from those proposed since they will be based on more complete data. Consequently, further revision of the hierarchy, using the above principles, may be necessary in the final rule.

At this time, we would revise the surgical hierarchy for MDCs 3, 5, 8, and 12 and the pre-MDC DRGs.

- In the pre-MDC DRGs, we propose to reorder Tracheostomy Except for Mouth, Larynx, or Pharynx Disorder (DRG 483) above Bone Marrow Transplant (DRG 481).

- In MDC 3, we propose to reorder Myringotomy with Tube Insertion (DRGs 61 and 62) above Cleft Lip and Palate Repair (DRG 52) and reorder Sinus and Mastoid Procedures (DRGs 53 and 54) above Sialoadenectomy (DRG 50).

- In MDC 5, we propose to reorder Amputation for Circulatory System Disorders Except Upper Limb and Toe (DRG 113) above Permanent Cardiac Pacemaker Implant or AICD Lead or Generator Procedure (DRGs 115 and 116) and to reorder Upper Limb and Toe Amputation for Circulatory System Disorders (DRG 114) above Cardiac Pacemaker (DRGs 117 and 118).

- In MDC 8, we propose to reorder Foot Procedures (DRG 225) above Major Shoulder/Elbow Procedures or Other Upper Extremity Procedures with CC (DRG 223).

- In MDC 12, we propose to reorder Testes Procedures (DRGs 338, 339, and 340) above Transurethral Prostatectomy (DRGs 336 and 337).

7. Refinement of Complications and Comorbidities List

There is a standard list of diagnoses that are considered complications or comorbidities (CCs). This list was developed by physician panels to include those diagnoses that, when present as a secondary condition, would

be considered a substantial complication or comorbidity. In preparing the original CC list, a substantial CC was defined as a condition that, because of its presence with a specific principal diagnosis, would increase the length of stay by at least one day for at least 75 percent of the patients.

In previous years, we have made changes to the standard list of CCs, either the addition of new CCs or the deletion of CCs already on the list. For FY 1993, we are not proposing to make any changes to the current CC list.

In the September 1, 1987 final notice concerning changes to the DRG classification system (52 FR 33143), we modified the GROUPE logic so that certain diagnoses included on the standard list of CCs would not be considered a valid CC in combination with a particular principal diagnosis. Thus, we created the CC Exclusions List. We made these changes to preclude coding of closely related conditions, to preclude duplicative coding or inconsistent coding from being treated as CCs, and to ensure that cases are appropriately classified between the complicated and uncomplicated DRGs in a pair.

In the May 19, 1987 proposed notice concerning changes to the DRG classification system (52 FR 18877), we explained that the excluded secondary diagnoses were established using the following five principles:

- Chronic and acute manifestations of the same condition should not be considered CCs for one another (as subsequently corrected in the September 1, 1987 final notice (52 FR 33154)).
- Specific and nonspecific (that is, not otherwise specified (NOS)) diagnosis codes for a condition should not be considered CCs for one another.
- Conditions that may not co-exist, such as partial/total, unilateral/bilateral, obstructed/unobstructed, and benign/malignant, should not be considered CCs for one another.
- The same condition in anatomically proximal sites should not be considered CCs for one another.
- Closely related conditions should not be considered CCs for one another.

The creation of the CC Exclusions List was a major project involving hundreds of codes. The FY 1988 revisions were intended to be only a first step toward refinement of the CC list in that the criteria used for eliminating certain diagnoses from consideration as CCs were intended to identify only the most obvious diagnoses that should not be considered complications or comorbidities of another diagnosis. For that reason and in light of comments

and questions on the CC list, we have continued to review the remaining CCs to identify additional exclusions and to remove diagnoses from the master list that have been shown not to meet the definition of a CC, stated above, as appropriate. (See the September 30, 1988 final rule for the revision made for the discharges occurring in FY 1989 (53 FR 38485), the September 1, 1989 final rule for the revision made for discharges occurring in FY 1990 (54 FR 36552), the September 4, 1990 final rule for the revision made for discharges occurring in FY 1991 (55 FR 36126), and the August 30, 1991 final rule for the revision made for discharges occurring in FY 1992 (56 FR 43209).)

We are proposing a limited revision of the CC Exclusions List to take into account the changes that will be made in the ICD-9-CM diagnosis coding system effective October 1, 1992. (See section II.B.9, below, for a discussion of these changes.) These proposed changes are being made in accordance with the principles established when we created the CC Exclusions List in 1987.

Tables 6g and 6h in section IV of the addendum to this proposed rule contain the proposed revisions to the CC Exclusions List that would be effective for discharges occurring on or after October 1, 1992. Each table shows the principal diagnoses with proposed changes to the excluded CCs. Each of these principal diagnoses is shown with an asterisk and the additions or deletions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.

CCs that are added to the list are in Table 6g—Additions to the CC Exclusions List. Beginning with discharges on or after October 1, 1992, the indented diagnoses will not be recognized by the GROUPE as valid CCs for the asterisked principal diagnosis.

CCs that are deleted from the list are in Table 6h—Deletions from the CC Exclusions List. Beginning with discharges on or after October 1, 1992, the indented diagnoses will be recognized by the GROUPE as valid CCs for the asterisked principal diagnosis.

Copies of the original CC Exclusions List applicable to FY 1988 can be obtained from the National Technical Information Service (NTIS) of the Department of Commerce. It is available in hard copy for \$73.00 and on microfiche for \$19.00, plus \$3.00 for shipping and handling. A request for the FY 1988 CC Exclusions List (which should include the identification accession number, ((PB) 88-133970),

should be made to the following address: National Technical Information Service, United States Department of Commerce, 5285 Port Royal Road, Springfield, Virginia 22161 or by calling (703) 487-4650.

Users should be aware of the fact that all revisions to the CC Exclusions List (FYs 1989, 1990, 1991, and 1992) and those in Tables 6g and 6h of this document must be incorporated into the list purchased from NTIS in order to obtain the CC Exclusions List applicable for discharges occurring on or after October 1, 1992.

Alternatively, the complete documentation of the GROUPE logic, including the current CC Exclusions List, is available from 3M/Health Information Systems (HIS), which, under contract with HCFA, is responsible for updating and maintaining the GROUPE program. The current DRG Definitions Manual, Eighth Revision, is available for \$195.00, which includes \$15.00 for shipping and handling. The Ninth Revision of this manual, which will include the changes proposed in this document as finalized in response to public comment, will be available in September 1992 for \$195.00. These manuals may be obtained by writing 3M/HIS at: 100 Barnes Road, Wallingford, Connecticut 06492 or by calling (203) 949-0303.

Please specify the revisions requested.

8. Review of Procedure Codes in DRGs 468 and 477

Each year, we review cases assigned to DRG 468 (Extensive OR Procedure Unrelated to Principal Diagnosis) in order to determine whether, in conjunction with certain principal diagnoses, there were certain procedures performed that are not currently included in the surgical hierarchy for the MDC in which the diagnosis falls. In FY 1989, this review resulted in the addition of DRG 476 (Prostatic OR Procedure Unrelated to Principal Diagnosis) and DRG 477 (Nonextensive OR Procedure Unrelated to Principal Diagnosis). For a detailed discussion of these changes, see the September 30, 1988 final rule (53 FR 38487).

Since DRG 468 is reserved for those cases in which none of the OR procedures is related to the principal diagnosis, it is intended to capture atypical cases, that is, those cases not occurring with sufficient frequency to represent a distinct, recognizable clinical group. DRGs 476 and 477 are assigned to specific subsets of these cases. DRG 476 is currently assigned to those discharges in which a prostatic

procedure is performed that is unrelated to the principal diagnosis.

DRG 477 is assigned to those discharges in which the only procedures performed are nonextensive procedures that are unrelated to the principal diagnosis. The original list of the ICD-9-CM procedure codes for the procedures we consider nonextensive procedures if performed with an unrelated principal diagnosis was published in Table 6c in section IV of the addendum to the September 30, 1988 final rule (53 FR 38591). As a part of the September 4, 1990 final rule, we moved a large number of procedures from DRG 468 to 477. We listed the procedure codes in Table 6g in section IV of the addendum to that final rule (55 FR 36135).

We annually conduct a review of procedures producing DRG 468 or 477 assignments on the basis of volume of cases in these DRGs with each procedure. Our medical consultants then identify those procedures occurring in conjunction with certain principal diagnoses with sufficient frequency to justify adding them to one of the surgical DRGs for the MDC in which the diagnosis falls. This year's review did not identify any changes that are necessary; therefore, we are not proposing to move any procedures from DRGs 468 or 477 to one of the surgical DRGs.

We also reviewed the list of OR procedures that produce DRG 468 assignments to ascertain if any of those procedures should be moved to the list of nonextensive procedures that produce DRG 477 assignments. We analyzed the charge and length of stay data for cases assigned to DRG 468 to identify those procedures that are associated with discharges that are more similar to the discharges that currently group to DRG 477 than to the discharges that group to DRG 468. Generally, we consider moving only those procedures for which we have an adequate number of discharges to analyze the data.

Based on our analysis, we are proposing to add the following four procedures to the list of nonextensive procedures that group to DRG 477:

- 04.41 Decompression of trigeminal nerve root.
- 04.42 Other cranial nerve decompression.
- 04.44 Release of tarsal tunnel.
- 04.49 Other peripheral nerve or ganglion decompression or lysis of adhesions.

These cases would group to DRG 477 instead of DRG 468 beginning with discharges on or after October 1, 1992.

9. Changes to the ICD-9-CM Coding System

As discussed above in section II.B.1 of this preamble, the ICD-9-CM is a coding system which is used for the reporting of diagnoses and procedures performed on a patient. In September 1985, the ICD-9-CM Coordination and Maintenance Committee was formed. This is a Federal interdepartmental committee charged with the mission of maintaining and updating the ICD-9-CM. This includes approving coding changes, developing errata, addenda, and other modifications to the ICD-9-CM to reflect newly developed procedures and technologies and newly identified diseases. The Committee is also responsible for promoting the use of Federal and non-Federal educational programs and other communication techniques with a view toward standardizing coding applications and upgrading the quality of the classification system.

The Committee is co-chaired by the National Center for Health Statistics (NCHS) and HCFA. The NCHS has lead responsibility for the ICD-9-CM diagnosis codes included in Volume 1—Diseases: Tabular List and Volume 2—Diseases: Alphabetic Index, while HCFA has lead responsibility for the ICD-9-CM procedure codes included in Volume 3—Procedures: Tabular List and Alphabetic Index.

The Committee encourages participation in the above process by major health-related organizations. In this regard, the Committee holds public meetings for discussion of educational issues and proposed coding changes. These meetings provide an opportunity for representatives of recognized organizations in the coding fields, such as the American Health Information Management Association (AHIMA) (formerly American Medical Record Association (AMRA)), the American Hospital Association (AHA), and various physician specialty groups as well as physicians, medical record administrators, and other members of the public to contribute ideas on coding matters. After considering the opinions expressed at the public meetings and in writing, the Committee formulates recommendations, which then must be approved by the agencies.

The Committee presented proposals for coding changes at public meetings held on May 2, August 1 and 2, and December 5 and 6, 1991 and finalized the coding changes after consideration of comments received at the meetings and in writing in the 30 days following the December 1991 meeting. The initial meeting for consideration of coding

issues for resolution in FY 1993 will be held on May 7, 1992. Copies of the minutes of these meetings may be obtained by writing to the co-chairpersons representing NCHS and HCFA. We encourage commenters to address suggestions on coding issues involving diagnosis codes to: Sue Meads, R.R.A. Co-Chairperson, ICD-9-CM Coordination and Maintenance Committee, NCHS, rm. 9-58, 6525 Belcrest Road, Hyattsville, Maryland 20782.

Questions and comments concerning the procedure codes should be addressed to: Patricia E. Brooks, Co-Chairperson, ICD-9-CM Coordination and Maintenance Committee, HCFA, Office of Coverage and Eligibility Policy, rm. 401 East High Rise Building, 6325 Security Boulevard, Baltimore, Maryland 21207.

The ICD-9-CM code changes that have been approved will become effective October 1, 1992. The new ICD-9-CM codes are listed, along with their proposed DRG classifications, in Tables 6a and 6b (New Diagnosis Codes and New Procedure Codes, respectively) in section IV of the addendum to this proposed rule. As we stated above, the code numbers and their titles were presented for public comment in the ICD-9-CM Coordination and Maintenance Committee meetings. Both oral and written comments were considered before the codes were approved. Therefore, we are soliciting comments only on the proposed DRG classification.

Further, the Committee has approved the expansion of certain ICD-9-CM codes to require an additional digit for valid code assignment. Diagnosis codes that have been replaced by expanded codes or have been deleted are in Table 6c (Invalid Diagnosis Codes). Procedure codes that have been replaced by expanded codes or have been deleted are in Table 6d (Invalid Procedure Codes). These diagnosis and procedure codes will not be recognized by the GROUPE beginning with discharges occurring on or after October 1, 1992. The corresponding new expanded codes are included in Tables 6a and 6b. Revisions to diagnosis and procedure code titles are in Tables 6e (Revised Diagnosis Code Titles) and 6f (Revised Procedure Code Titles), which also include the proposed DRG assignments for these revised codes.

C. Recalibration of DRG Weights

We are proposing to use the same basic methodology for the FY 1993 recalibration as we did for FY 1992. (See the August 30, 1991 final rule (56 FR

43218). That is, we would recalibrate the weights based on charge data for Medicare discharges. However, we would use the most current charge information available, the FY 1991 MEDPAR file, rather than the FY 1990 MEDPAR file. The MEDPAR file is based on fully-coded diagnostic and surgical procedure data for all Medicare inpatient hospital bills.

The proposed recalibrated DRG relative weights are constructed from FY 1991 MEDPAR data, received by HCFA through December 1991, from all hospitals subject to the prospective payment system and short-term acute care hospitals in waiver States. The FY 1991 MEDPAR file includes data for approximately 10.2 million Medicare discharges.

The methodology used to calculate the proposed DRG relative weights from the FY 1991 MEDPAR file is as follows:

- All the claims were regrouped using the proposed DRG classification revisions discussed above in section II.B of this preamble.

- Charges were standardized to remove the effects of differences in area wage levels, indirect medical education costs, disproportionate share payments, and, for hospitals in Alaska and Hawaii, the applicable cost-of-living adjustment.

- The average standardized charge per DRG was calculated by summing the standardized charges for all cases in the DRG and dividing that amount by the number of cases classified in the DRG.

- We then eliminated statistical outliers using the same criterion as was used in computing the current weights. That is, all cases outside of 3.0 standard deviations from the mean of the log distribution of charges per case for each DRG were eliminated.

- The average charge for each DRG was then recomputed excluding the statistical outliers and divided by the national average standardized charge per case to determine the weighting factor.

- We established the weighting factor for heart transplants (DRG 103) in a manner consistent with the methodology for all other DRGs except that the heart transplant cases that were used to establish the weight were limited to those Medicare-approved heart transplant centers that have cases in the FY 1991 MEDPAR file. Similarly, we limited the liver transplant cases that were used to establish the weight for DRG 480 (Liver Transplant) to those hospitals that are Medicare-approved liver transplant centers.

- Acquisition costs for kidney, heart, and liver transplants continue to be paid on a reasonable cost basis. Unlike other excluded costs, the acquisition costs are

concentrated in specific DRGs (DRG 302 (Kidney Transplant); DRG 103 (Heart Transplant); and DRG 480 (Liver Transplant)). Because these costs are paid separately from the prospective payment rate, it is necessary to make an adjustment to prevent the relative weights for these DRGs from including the effect of the acquisition costs. Therefore, we subtracted the acquisition charges from the total charges on each transplant bill that showed acquisition charges prior to computing the average charge for the DRG and prior to eliminating statistical outliers.

When we recalibrated the DRG weights for previous years, we set a threshold of 10 cases as the minimum number of cases required to compute a reasonable weight. In the FY 1990 MEDPAR data used to establish the FY 1992 weights, there were 37 DRGs that contained fewer than 10 cases. We propose to use that same case threshold in recalibrating the DRG weights for FY 1993. Using the FY 1991 MEDPAR data set, there are 38 DRGs that contain fewer than 10 cases. We computed the weight for the 38 low-volume DRGs by adjusting the original weights of these DRGs by the percent change in the average weight of the cases in the remaining DRGs.

The weights developed according to the methodology described above, using the proposed DRG classification changes, result in an average case weight that is different from the average case weight before recalibration. Therefore, the new weights are normalized by an adjustment factor, so that the average case weight after recalibration is equal to the average case weight prior to recalibration. This adjustment is intended to ensure that recalibration by itself neither increases nor decreases total payments under the prospective payment system.

Section 1886(d)(4)(C)(iii) of the Act requires that reclassification and recalibration changes beginning with FY 1991 be made in a manner that assures that the aggregate payments are neither greater than nor less than the aggregate payments that would have been made without the changes. We interpret section 1886(d)(4)(C)(iii) of the Act to require that we ensure the FY 1993 reclassification and recalibration changes do not affect aggregate payments. Although normalization is intended to achieve this effect, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals. Therefore, as discussed in section II.A.4.b of the Addendum to this

proposed rule, we are proposing to make a budget neutrality adjustment to assure the requirement of section 1886(d)(4)(C)(iii) of the Act is met.

D. FY 1991 DRG Classification Changes and Their Effect on DRG Relative Weights and Payments

As described above in sections II.B and C of this preamble, each year we make changes to the DRG classifications in addition to recalibrating the relative weights based on the most recent charge data available. In the September 4, 1990 final rule, we made several major modifications to the DRGs effective with discharges occurring on or after October 1, 1990 (FY 1991). These changes included creating two new DRGs for liver and bone marrow transplants, which had recently been approved for coverage under the Medicare program. In addition, we added two DRGs for cases in which a tracheostomy is performed: one for patients with a disorder of the mouth, larynx, or pharynx and one for all other patients. Cases are assigned to these four DRGs prior to assignment to one of the MDCs.

We also added two new MDCs, one for multiple significant trauma (MDC 24) and one for human immunodeficiency virus (HIV) infections (MDC 25), and we placed these two MDCs ahead of the other MDCs in the GROUPE. Thus, cases are assessed for assignment to these DRGs before the other 23 MDCs. MDC 24 consists of four DRGs (three surgical and one medical) and MDC 25 is made up of three DRGs (one surgical and two medical).

The FY 1991 changes were designed to improve payment equity by increasing the amount of variation in resource costs explained by the DRGs. For the most part, these new DRGs have extremely high weights, and the cases that are now classified to them receive much higher payments than they would have absent the changes.

When changes in DRG classifications are made, we account for the effect the changes will have on future program payments through the recalibration and normalization of the DRG weights. In the year in which the changes are effective, they are intended to be budget neutral; that is, the payments in that year should be no more or no less than the payments would have been without the changes. As discussed in more detail above, in section II.C of this preamble, recalibration is accomplished by processing the most recent, complete MEDPAR data through a revised GROUPE that encompasses the DRG classification changes and reweighting the DRGs based on the charges

submitted by the hospitals. After recalibration is complete, the new weights are normalized by an adjustment factor. The normalization process compares the average case weight before recalibration to the average case weight after reclassification and recalibration using the same set of MEDPAR data, and an adjustment is made to the new weights so that these two average case weights are the same.

When we conducted the normalization of the FY 1991 DRG weights, we used the FY 1989 MEDPAR data. The FY 1989 claims were first mapped into their FY 1990 equivalents and processed through the FY 1990 GROUPE to determine the average case weight for that year. Those same data were then remapped into their FY 1991 equivalents and processed through the FY 1991 GROUPE to estimate what would be the average case weight during that year. The new DRG weights were then adjusted so that the two average case weights (FYs 1990 and 1991) are equal. (In addition to this process, we also made a budget neutrality adjustment to ensure that aggregate payments made in FY 1991

would be no more than and no less than they would have been absent the DRG and wage index changes.)

Now that the MEDPAR file for FY 1991 is available, we can evaluate the effect of the new DRGs on the actual distribution of cases under the revised DRGs. We find that many more cases than we had originally estimated were classified into the new DRGs. In addition, there are many DRGs that experienced at least a 20 percent increase or decrease in percentage of cases assigned between FY 1989 and FY 1991 when both sets of cases are grouped using the FY 1991 GROUPE. These include several of the new DRGs, other DRGs that were revised effective with FY 1991, and some DRGs for which there was no major change.

The effect of these unanticipated changes in the distribution of cases and the resulting increase in average DRG weight resulted in a 1 percent increase in Medicare inpatient hospital program payments compared to the payments that would have resulted if we had not made DRG reclassification and recalibration changes in FY 1991. If we had been in possession of the actual FY 1991 cases when we established the

weights for FY 1991, the overall average case-mix index would have been 0.99 percent lower than the actual FY 1991 case-mix index. The total case-mix change between FY 1990 and FY 1991 was 2.5 percent.

Although there can be many reasons for increases in the relative number of cases assigned to a particular DRG, including an increase in the frequency with which procedures are performed or an increase in inpatient treatment of certain diagnoses, we believe that the 1 percent increase attributable to the DRG classification and recalibration changes was, for the most part, caused by coding improvements made in response to the FY 1991 DRG changes. The increase in cases assigned to higher-weighted DRGs is most dramatic in the new tracheostomy DRG 483 and the three new HIV-related DRGs (488 through 490). When the FY 1989 and 1991 cases are separately classified using the FY 1991 GROUPE, the number of cases assigned to DRG 483 increases 30 percent between the 2 years and the number of cases assigned to DRGs 488 through 490 increases by 123 percent. The following table illustrates the changes:

DRG	Number of cases in DRG		DRG cases as percent of total cases		
	Estimate	Actual	Estimate	Actual	Percent increase
483	25,191	32,751	0.25	0.32	30
488	261	473	0.003	0.005	81
489	1,801	4,187	0.02	0.04	133
490	780	1,679	0.01	0.02	115
Total MDC 24	2,842	5,334	0.03	0.06	123
Total cases	28,013	39,085	0.28	0.38	40

As noted above, we believe that the increases in the tracheostomy and HIV DRGs are due to the fact that hospitals changed their coding practices between FYs 1989 and 1991 in response to the FY 1991 DRG changes. Before implementation of the FY 1991 changes, there was no incentive to code a tracheostomy outside of MDC 4 nor was

there any incentive to code secondary diagnoses of HIV. However, once these codes became significant for correct DRG classification, they were included on claims where they might previously have been left off.

Based on our analysis of the FY 1989 MEDPAR, we estimated that 55 percent of the cases reassigned to DRG 483

would have been classified to DRG 474 (Respiratory System Diagnoses with Ventilator Support) in MDC 4 before the FY 1991 changes. However, the actual number of cases reassigned from DRG 474 was lower while the number of cases reassigned from all other DRGs increased dramatically. The following table demonstrates these changes:

BREAKDOWN OF CASES ASSIGNED TO DRG 483 IN FY 1991

FY 1989 DRG	Estimate		Actual	
	Number of cases	Per-cent of DRG 483 cases	Number of cases	Per-cent of DRG 483 cases
DRG 474	13,929	55	11,851	36
All other DRGs	11,262	45	20,900	64
Total	25,191	100	32,751	100

This indicates that a significant number of cases assigned to other DRGs in the FY 1989 MEDPAR did not include a code for a tracheostomy procedure that was performed during the stay. Because DRG 483 had such a high relative weight in FY 1991 (14.0597) compared to the DRGs from which these cases were reclassified, the inability to predict correctly the actual case distribution resulted in a substantial unanticipated increase in program payments.

The new DRGs created for HIV cases experienced a similar influx of cases. In this case, the actual FY 1991 cases came from the DRGs we had predicted they would; however, they came in much larger numbers than we had estimated. For example, based on our analysis of the FY 1989 MEDPAR, we predicted that 21 percent of the cases reassigned to DRG 489 (HIV with Major Related Condition) would have been assigned to DRG 79 (Respiratory Infections and Inflammations with CC) absent the reclassification. The actual percentage

of FY 1991 cases assigned to DRG 489 that would have been assigned to DRG 79 remained virtually constant at 22 percent. However, the estimated number of cases was 385 and the actual number was 922. Therefore, even though we correctly predicted the percent of cases in DRG 489 that would move from DRG 79, the number of cases more than doubled. While we recognize the incidence of HIV may have increased between FY 1989 and 1991, we believe a 123 percent increase must also be attributable to improved coding for HIV infection.

On a smaller scale, this type of change in coding happens every year in response to DRG changes. One example of such a change is the deletion of diagnoses from the list of CCs. When CCs are present in a case, hospitals will make sure to code at least one CC in order to classify a case in the higher-weighted "with CC" DRG. However, if that CC is deleted from the list of recognized CCs for the DRG and we predict that the case would now be

classified in the non-CC DRG, it is possible that hospitals will simply code another CC present in the medical record in order to achieve the "with CC" classification. Therefore, cases that we had predicted would be classified to the "without CC" DRG actually remain as CC cases because of a change in coding.

Based on the FY 1989 MEDPAR, we had estimated that CC revisions effective for FY 1991 would change the distribution of cases in DRGs 320 and 321 (Kidney and Urinary Tract Infections Age > 17) by decreasing the number of cases assigned to DRG 320 (with CC). (The number of cases assigned to DRG 321 were estimated to remain about the same.) However, the actual number of cases assigned to DRG 320 in the FY 1991 MEDPAR file increased and the number of cases assigned to DRG 321 decreased. The number of cases assigned to DRGs 320 and 321 and their percent of total MEDPAR cases are shown below:

	Relative weight	Estimate DRG cases		Actual DRG cases	
		Number of cases	As percent of total cases	Number of cases	As percent of total cases
DRG 320	1.0055	145,039	1.47	162,874	1.60
DRG 321	.6507	34,523	0.38	28,718	0.28

Thus, the number of cases assigned to the higher-weighted DRG increased from the number we had estimated, and the number of cases assigned to the lower-weighted DRG decreased. As with DRG 483, the coding practice changes made in response to our reclassification of CCs resulted in additional program payments beyond those we had estimated.

This can also happen in response to surgical hierarchy changes or to changes in the procedures that effect classification. This can be seen in the movement of cases in MDC 5 between FYs 1989 and 1991. We completely reconstructed the majority of the surgical DRGs in MDC 5 effective for FY 1991 and there were significant deviations from the estimated frequency for each DRG. For example, the changes made in MDC 5 for FY 1991 resulted in a tremendous increase of cases coded with percutaneous cardiovascular procedures. We assigned these cases to DRG 112 effective with FY 1991 and, based on the FY 1989 MEDPAR, we estimated that 83,614 cases would group to this DRG. The FY 1991 MEDPAR

shows that 128,778 cases were assigned to this DRG, an increase of 54 percent. Although this is the DRG that changed the most in terms of number of cases, virtually all of the revised MDC 5 DRGs experienced some change in the number of cases assigned in FY 1991 as opposed to our estimates.

Although we have experienced this type of case-mix increase before (see the September 1, 1989 final rule for a discussion of the inflationary effect of the FY 1987 DRG changes (54 FR 36469)), we are particularly concerned about this problem in light of the fact that we are seriously considering major changes to the DRG system to better explain the effects of severity of illness. Besides the mandate of section 1886(d)(4)(C)(iii) of the Act, which provides that aggregate payments may not be affected by DRG reclassification and recalibration changes, we do not believe it is prudent policy to make changes for which we cannot predict the effect on the case-mix index and, thus, payments.

Although we can predict that changes in certain hospital coding practices may

result from DRG changes we make, it is not possible to predict which claims will be affected by these changes. Thus, in the reclassification and recalibration process, we can rely only on the code information included on actual cases. We are hoping that the expansion of the hospital bill to include nine diagnosis and six procedure codes will help to alleviate our problem to some extent. However, this change went into effect on April 1, 1992 and, thus, will not be reflected in a full year of MEDPAR data until FY 1993, which means it will not be available to us for purposes of weight construction until FY 1995.

We are strongly committed to making changes in the DRG system to improve payment equity; however, our current inability to predict the changes in coding behavior that may result from our revisions limits the extent to which we are willing to revise the system. Until such time as we are able either to improve our ability to predict coding changes by validating in advance the impact that potential DRG classification changes may have on coding behavior

or to make methodological changes to prevent building the inflationary effects of the coding changes into future program payments, we intend to make only relatively insignificant changes in the DRG classification system. As a general policy, we will consider the changes to be insignificant if, in the aggregate, we estimate that program payments would increase by less than 0.1 percent or \$60 million if we have underestimated by 10 percent the number of cases that would receive more favorable payment under the DRG classification changes that provide incentives for coding improvement.

In this proposed rule, we believe that the proposed changes to MDC 4 and 17 involving certain endoscopic procedures and to MDC 20 involving recognition of OR procedures provide incentives for coding improvement since they involve recognition of procedures that do not currently affect DRG assignment. If we have made a 10 percent underestimation in the number of cases that are directly affected by these classification changes, we estimate that program payments would increase by .0204 percent, or \$12 million. The potential for increased program payments is mostly related to our proposal to recognize certain endoscopic procedures as OR procedures.

Based on current coding practices, we estimate approximately 32,000 cases in MDCs 4 and 17 that are currently assigned to medical DRGs with an average case weight of 1.36508 would be assigned to surgical DRGs with an average case weight of 2.27465. If we have underestimated by 10 percent the number of cases that would be paid as surgical DRGs, program payments would increase by .02 percent. If we have underestimated by 10 percent the number of cases that would be affected by the DRG 20 change, we estimate program payments would increase by .0004 percent. Although we are proposing all changes that we believe are appropriate this year, this general policy will preclude our making significant refinements to the DRG system until we are able to protect program payments against the inflationary impact of those changes.

One approach to this problem that we have considered is maintaining the average case weight at 1.0 after recalibration, thereby eliminating the process of normalization. In other words, after recalibration, we would not scale the new weights upward to carry forward the cumulative effects of past case-mix increases. We would, instead, make an adjustment or include in the annual update factor a specific

allowance for any real case-mix change that occurred during the previous year. This is a relatively simple and straightforward system for preventing the effects of year-to-year increase in case-mix index from accumulating in the DRG weights.

This methodology would have several advantages. First, it would be an easy and effective means of removing from the payment base inappropriate year-to-year case-mix increase (that is, case-mix increases mainly due to changes in coding practices). It would also streamline the current process of adjustments, where recalibration of the weights is followed by normalization, and the recommended update factor includes a negative adjustment to offset all case-mix increase estimated for the previous year followed by a positive increase to add back the real case-mix increase (that is, a genuine increase in the resources required to treat patients). Finally, the change would restore the meaning of the relative weights by bringing the average weight back to 1.0 each year. Thus, 1.0 would reflect the average resources used to treat the average Medicare inpatient hospital case, while a weight of 2.0 would reflect a case that requires twice the average resources to treat and a weight of 0.5 would reflect a case that requires one-half the average resources. Since the estimated average FY 1991 DRG relative weight is 1.367, this type of comparison is not readily accomplished using normalized DRG relative weights.

We are soliciting public comment on this and other possible approaches that could be implemented in the future by legislation or administratively to account for coding changes that result from revisions in the DRGs. Your comments should take our statutory mandates for prospectivity and budget neutrality into account.

III. Proposed Changes to the Hospital Wage Index

A. Background

Sections 1886(d)(2)(H) and 1886(d)(3)(E) of the Act require that the standardized urban and rural amounts be adjusted for area variations in hospital wage levels as part of the methodology for determining prospective payments to hospitals. To fulfill this requirement, we construct an index that reflects average hospital wages in each urban and rural area as a percentage of the national average hospital wage.

For determining prospective payments to hospitals in FY 1992, the wage index is based on a HCFA survey of hospital wage and salary data for all hospitals

subject to the prospective payment system with cost reporting periods ending in calendar year 1988. Home office costs and fringe benefits associated with hospital and home office salaries were included in the updated wage index. Nonhospital costs were excluded from the wage index. The FY 1992 wage index reflected all corrections that had been made in the wage survey data through August 15, 1991.

Section 1886(d)(3)(E) of the Act requires that the hospital wage index be updated annually beginning October 1, 1993.

B. Updating the Wage Index Data

For discharges occurring on or after October 1, 1992, the proposed wage index would continue to be based solely on 1988 wage data. In addition, in determining the proposed wage index, we incorporated all corrections of errors that have been identified in the survey wage data since the construction of the wage index implemented for FY 1992 in the August 30, 1991 final rule.

The wage indexes are shown in Tables 4a through 4c in the addendum to this proposed rule.

C. Revisions to the Wage Index Based on Hospital Reclassifications

Under section 1886(d)(8)(B) of the Act, for discharges occurring on or after October 1, 1988, hospitals in certain rural counties adjacent to one or more Metropolitan Statistical Areas (MSAs) are considered to be located in one of the adjacent MSAs if certain standards are met.

Under section 1886(d)(10) of the Act the Medicare Geographic Classification Review Board (MGCRRB) considers applications by hospitals for geographic reclassification for purposes of payment under the prospective payment system. The first hospital reclassifications based on the decisions of the MGCRRB took effect on October 1, 1991.

The methodology for determining the wage index values for redesignated hospitals is applied jointly to the hospitals located in those rural counties that were deemed urban under section 1886(d)(8)(B) of the Act and those hospitals that were reclassified as a result of the MGCRRB decisions under section 1886(d)(10) of the Act. Section 1886(d)(8)(C) of the Act provides that the application of the wage index to redesignated hospitals is dependent on the hypothetical impact that the wage data from these hospitals would have on the wage index value for the MSA to which they have been redesignated. Therefore, the wage index values were

determined by considering the following:

- If including the wage data for the redesignated hospitals reduces the MSA wage index value by 1 percentage point or less, the MSA wage index value applies to the redesignated hospitals deemed to be a part of that MSA. The MSA wage index value is determined exclusive of the wage data for the redesignated hospitals.

- If including the wage data for the redesignated hospitals reduces the wage index value for the area to which the hospitals are redesignated by more than 1 percentage point, the hospitals that are redesignated are subject to the wage index value of the area that results from including the wage data of the redesignated hospitals. However, the resulting wage index value for the redesignated hospitals cannot be less than the wage index value for the rural areas of the State in which the hospitals are located.

- Rural areas whose wage index values would be reduced by excluding the data for hospitals that have been redesignated to another area continue to have their wage index calculated as if no redesignation had occurred. Those rural areas whose wage index values increased as a result of excluding the wage data for the hospitals that have been redesignated to another area have their wage index calculated exclusive of the redesignated hospitals.

- The wage index value for an urban area is calculated exclusive of the wage data for hospitals that have been reclassified to another area. However, the wage index for an urban area may not be reduced, as a result of geographic reclassification, below the Statewide rural average.

We note that, except for those rural areas where redesignations would reduce the rural wage index value, the wage index value for each area is computed exclusive of the data for hospitals that have been redesignated from the area for purposes of their wage index. As a result, there are a few MSAs listed in Table 4a that have no hospitals remaining in the MSA. This is because the hospitals in the original MSA have been reclassified to another area by the MGCRB and our records indicate that there are no other hospitals currently classified in those areas. For those areas, we have listed the Statewide rural wage index value.

The proposed revised wage index values effective for discharges occurring on or after October 1, 1992 are shown in Tables 4a, 4b, and 4c of the addendum to this proposed rule. Hospitals that are redesignated should use the wage index values shown in Table 4c. It should be

noted that for some areas, more than one wage index value will be shown in Table 4c. This occurs when hospitals from more than one State are included in the group of redesignated hospitals, and one State has a higher Statewide rural wage index value than the wage index value otherwise applicable to the redesignated hospitals.

Revised Table Names

Table 4—Wage Index for Urban Areas

Table 4b—Wage Index for Rural Areas

Table 4c—Wage Index for Redesignated Hospitals

The proposed FY 1993 wage index values incorporate all reclassification decisions made by the MGCRB as of March 30, 1992. As of that date, there were 1,150 hospitals reclassified for purposes of the wage index (including hospitals reclassified under both sections 1886(d)(8)(B) and 1886(d)(10) of the Act). This number does not include MGCRB decisions that are still under review by the Administrator. At the time this proposed wage index was constructed, the MGCRB had completed its review. Any changes that result from appeals and the Administrator's review process will be incorporated into the wage index values to be published in the final rule. The changes may affect not only the wage index value for specific geographic areas, but also whether redesignated hospitals receive the wage index of the area to which they are redesignated or a combined wage index that includes the data for both the hospitals already in the area and the redesignated hospitals. Further, the wage index for the area from which the hospitals are redesignated may be affected.

We note that hospitals that have been reclassified by the "MGCRB are permitted to withdraw their applications within 45 days of the publication of this Federal Register document. The request for withdrawal of an application for reclassification that would be effective in FY 1993 must be received by the MGCRB by July 20, 1992.

We caution that the proposed wage index value will change in the final rule to take into account the impact of revisions in reclassification decisions resulting from the appeals and review process, any withdrawal requests, and any wage index corrections that are made before publication of the final rule. A hospital that requests to withdraw its application may not request that the MGCRB decision be reinstated after publication of the final notice of prospective payment rates.

D. Midyear Corrections to the Wage Index Values

It has been our policy under § 412.63(p)(2) to make midyear corrections to the hospital wage data and adjust the wage index for the affected areas on a prospective basis. However, implementation of mid-year corrections has resulted in several problems concerning the reclassification of hospitals by the MGCRB.

In the June 4, 1991 final rule with comment period affecting the MGCRB (56 FR 25477), we indicated that the MGCRB would use the latest updated survey data, including midyear corrections, to assess reclassification requests. We adopted this policy in order to ensure that hospitals whose applications were submitted based on corrected wage data would be treated fairly. However, because wage data corrections are processed on an ongoing basis throughout the year, the outcome of a hospital's reclassification request may in some cases depend entirely on whether the intermediary's audit and our subsequent processing of its wage correction are completed before the MGCRB issues its decision on the hospital's application. That is, since the MGCRB makes its determination based on the data available at the time a hospital's case is being considered, whether a hospital meets the criteria for reclassification for purposes of the wage index may depend on the timing of the implementation of a wage correction.

Also, under section 1886(d)(8)(C) of the Act, the wage index applicable to reclassified hospitals is dependent on the hypothetical impact that the wage data from these hospitals would have on the wage index value for the MSA to which they have been redesignated. As explained above, if the impact is a reduction of 1 percentage point or less, the reclassified hospitals receive the MSA wage index value. If the impact is a reduction of greater than 1 percentage point, the reclassified hospitals receive the wage index value that results from combining their wage data with the MSA data. This combined value is normally lower than the MSA value. Under our current policy, we have had instances in which a correction to the wage data for a hospital in an MSA has increased the impact of reclassifications on the MSA wage index value to greater than 1 percentage point. In these situations, reclassified hospitals that had been receiving the MSA wage index value became subject to the lower combined wage index value. Thus, solely as a result of another hospital's wage corrections, payments to these

reclassified hospitals were reduced midway through the fiscal year. These hospitals are confronted with an unanticipated reduction in revenues when their Medicare payments are abruptly reduced because of mid-year wage data corrections.

The current wage index based on 1988 calendar year data has been in effect since FY 1991. Thus, we believe that hospitals have had sufficient time to review their wage data and submit corrections where appropriate. Therefore, in order to resolve the problems described above, we are proposing to eliminate mid-year wage data corrections effective with requests for correction received on or after October 1, 1992.

Under this proposal, only those requests for wage data corrections that are submitted with supporting documentation and received by the fiscal intermediary no later than September 30, 1992 would be implemented as a mid-year wage index change. Changes based on those corrections would be made on a prospective basis in FY 1993 in accordance with our current policy. The specific requirements would be as follows:

- A hospital that wishes to make a correction to its reported wage data must submit to its fiscal intermediary a revised wage survey form (HCFA 2561) along with supporting documentation by no later than September 30, 1992.

- Within 30 days, the fiscal intermediary will review the data and adjust it as appropriate. Upon completion of its review, the fiscal intermediary will forward the hospital's request to the HCFA's Division of Hospital Payment Policy, along with a letter that summarizes the hospital's request and makes a recommendation concerning the appropriateness of the requested wage correction.

- HCFA will review the request and, if HCFA determines that a wage correction is warranted, the wage index value for the area in which the hospital is located will be revised on a prospective basis.

- In cases where the hospital submitted supporting documentation but additional information is required by the fiscal intermediary or HCFA, the hospital must submit the required information within 30 days of receiving the request.

As required by section 1886(d)(3)(E) of the Act, we will update the wage index data on an annual basis beginning October 1, 1993. We are currently collecting wage data on an ongoing basis as part of the Medicare cost report. Fiscal intermediaries are

transmitting these wage data through the Hospital Cost Report Information System (HCRIS). We expect to use the latest data available through HCRIS to update the wage index on an annual basis. A hospital that wishes to make corrections to the wage data reported on its Medicare cost report will do so through its fiscal intermediary in accordance with the normal cost report revision or reopening procedures. Fiscal intermediaries will forward any corrections to HCFA through HCRIS, and we will incorporate those corrections into the wage index on an annual basis, at the same time we update the wage index for payment purposes.

E. Revised Metropolitan Statistical Area (MSA) Definitions Based on 1990 Census Data

In the August 30, 1991 final rule (56 FR 43202), we indicated that the Office of Management and Budget (OMB) expected to issue revised MSA definitions based on 1990 census data in June 1992. We had anticipated implementing the new MSA definitions in the FY 1993 final rule in accordance with our policy of adopting MSA changes at the beginning of the Federal fiscal year following OMB's announcement (see § 412.63(b)(4)). However, we pointed out potential problems associated with implementing major MSA changes (such as reconfiguring the wage index and standardized amounts and determining appropriate geographic reclassifications) in a final rule without prior notification in the proposed rule. We also solicited public comments on possible approaches to implementing the revised MSA definitions.

However, because of significant delays in obtaining the necessary data from the Bureau of Census, OMB does not expect to publish the revised MSA definitions by June 30, 1992, as originally planned. As of April 1, 1992, the census data were still not available and the Federal Executive Committee on Metropolitan Areas, which makes recommendations to OMB concerning the MSA definitions, had not yet initiated its review.

The delay in publication of the new MSA definitions will not allow us sufficient time to implement the revised MSAs in the FY 1993 final rule, which must be published by September 1, 1992. Therefore, we now plan to implement the revised MSA definitions based on 1990 census data in FY 1994. Since OMB's originally expected publication date was actually 1 year ahead of normal schedule (the MSAs based on 1980 census data were announced in

1983 and implemented in FY 1984), implementation of the revised MSAs in FY 1994 is within the 10-year census period. Therefore, we will announce the revised MSAs and describe their effect on the wage index and geographic reclassifications in the FY 1994 proposed rule.

IV. Proposed Changes Concerning Reclassifications by the Medicare Geographic Classification Review Board

A. Background

Section 6003(h)(1) of the Omnibus Budget Reconciliation Act of 1989 (Pub. L. 101-239), enacted on December 19, 1989, added section 1886(d)(10) to the Act to provide for creation of the Medicare Geographic Classification Review Board (MGCRCB). On September 6, 1990, we published an interim final rule with comment period (55 FR 36754) that provided for the establishment of the MGCRCB and set forth the criteria for the MGCRCB to use in considering applications by hospitals for geographic reclassification for purposes of payment under the prospective payment system. The interim final rule also set forth requirements regarding the MGCRCB's composition and operational procedures. On June 4, 1991, we published a final rule with comment period (56 FR 25458) that responded to comments on the September 6, 1990 interim final rule and implemented provisions of the Omnibus Budget Reconciliation Act of 1990 (Pub. L. 101-508, enacted on November 5, 1990) concerning the MGCRCB.

Guidelines concerning the criteria and conditions for hospital reclassification are located at 42 CFR part 412 subpart L, §§ 412.230 through 412.236. (Regulations concerning MGCRCB composition and procedures are located at §§ 412.246 through 412.280.) The purpose of the criteria is to provide direction, to both the MGCRCB and those hospitals seeking geographic reclassification, with respect to the situations that merit an exception to the rules governing the geographic classification of hospitals for purposes of payment under the Medicare prospective payment system. Hospitals may be reclassified individually or as a group for purposes of their wage index or standardized amount or both.

A request for reclassification must be filed by October 1 of the Federal fiscal year preceding the Federal fiscal year for which the reclassification decision would be effective. For example, a request for reclassification effective for FY 1994 must be filed by October 1, 1992. The MGCRCB is required to issue its decision within 180 days of October 1, or

by March 30. A reclassification decision by the MGCRB is generally effective for 1-year. However, depending on its assessment of the facts supporting an individual hospital's or group of hospitals' request for reclassification, the MGCRB may provide for an automatic 1-year renewal of its decision.

Section 1886(d)(8)(D) of the Act requires that the effect of decisions of the MGCRB be budget neutral. Under this section, the Secretary is to adjust the standardized amounts for urban hospitals to ensure that total aggregate payments under the prospective payment system after implementation of the geographic reclassification provisions of sections 1886(d)(8)(B) and (C) and 1866(d)(10) of the Act are equal to the aggregate prospective payments that would have been made absent these provisions. Also, the standardized amounts for rural hospitals are to be adjusted to ensure that aggregate payments to rural hospitals not affected by these provisions neither increase nor

decrease as a result of implementation of these provisions.

The first reclassification decisions issued by the MGCRB became effective on October 1, 1991 for discharges occurring in FY 1992. On June 3, 1991, we published a proposed rule setting forth the proposed FY 1992 payment rates under the prospective payment system (56 FR 25178). The proposed FY 1992 standardized amounts and wage index values incorporated the reclassification decisions that had been made by the MGCRB as of March 30, 1991. The impact analysis in the proposed rule indicated that the reclassification decisions would have a significant impact on the distribution of program payments.

On August 30, 1991, we published a final rule (56 FR 43196) setting forth the FY 1992 prospective payment system rates. In the final rule, we responded to comments concerning the June 3, 1991 proposed rule and discussed the impact of the FY 1992 MGCRB reclassifications.

In addition, we responded to comments concerning the June 4, 1991 final rule with comment period on the MGCRB procedures and reclassification guidelines.

The August 30, 1991 final rule reflected 930 hospital reclassifications approved by the MGCRB and the HCFA Administrator as of August 5, 1991 and effective for FY 1992. Over 75 percent of all reclassified hospitals are located in rural areas. As the following chart indicates, 75 percent of the reclassified rural hospitals were reclassified for their wage index, 11 percent were reclassified for their standardized amount, and 14 percent were reclassified for both.

Twenty-five percent of the hospitals reclassified for FY 1992 are located in urban areas. Of the reclassified hospitals located in other urban areas, 45 percent were reclassified for their wage index, 45 percent were reclassified for their standardized amount, and 10 percent were reclassified for both.

DISTRIBUTION OF HOSPITALS RECLASSIFIED FOR FY 1992

Geographic location	Percent reclassified for both wage index value and standardized amount	Percent reclassified for standardized amount	Percent reclassified for wage index value
Large urban.....	1.9	0.0	98.1
Other urban.....	45.3	10.1	44.6
Rural.....	13.6	11.0	75.5

The effects of the MGCRB reclassification decisions on FY 1992 payments were significant. To meet the statutory budget neutrality requirements, each of the urban standardized amounts (large and other) was reduced 1.1 percent. Among all hospitals not reclassified, the overall impact of hospital reclassifications was an average decrease in payment per case of about 1 percent.

The overall impact on reclassified hospitals in FY 1992 was to increase their payment per case by an average 5.9 percent. Hospitals located in rural areas that were reclassified for purposes of both their wage index value and their standardized amount received an average increase of nearly 16 percent. Urban hospitals that were reclassified only for purposes of their standardized amounts received an average decrease in payments per case of 0.2 percent. This was because the average decrease in the wage index values for the urban areas from which other hospitals were reclassified for purposes of their wage index was greater than the average increase in urban standardized amounts after reclassification to a large urban area. The decrease also reflected the

budget neutrality adjustment for urban hospitals.

EFFECTS OF FY 1992 GEOGRAPHIC RECLASSIFICATIONS ON PAYMENTS PER CASE

	Percentage change in hospital payments per case from geographic reclassification
All reclassified hospitals.....	5.9
Standardized amount only.....	2.7
Wage index only.....	5.2
Both.....	8.8
All reclassified urban hospitals.....	3.7
Standardized amount only.....	-0.2
Wage index only.....	2.9
Both.....	15.9
All reclassified rural hospitals.....	8.0
Standardized amount only.....	5.7
Wage index only.....	6.8
Both.....	15.8
All nonreclassified hospitals.....	-1.0
Urban nonreclassified hospitals.....	-1.0
Rural nonreclassified hospitals.....	-0.1

(The above analysis pertains to the impact of the FY 1992 geographic reclassifications. Comparable data for

FY 1993 reclassifications may be found in Appendix A of this proposed rule. We note that the number of hospital reclassifications has increased from 930 in FY 1992 to 1249 in FY 1993.)

In the August 30, 1991 final rule (56 FR 43198), we discussed comments concerning geographic reclassification issues raised in the June 3, 1991 and June 4, 1991 Federal Register documents. Many commenters addressed the impact of geographic reclassification on payments to hospitals.

Several commenters stated that we should suspend implementation of the June 4, 1991 final rule and extend the application deadline for FY 1993 reclassifications in order to allow time to reevaluate the appropriateness of the guidelines. A number of commenters pointed out potential problems with the application process in future years. In response to the comments, we stated that we intended to evaluate the FY 1992 reclassifications made under the current guidelines and to propose such revisions as may be appropriate for future application cycles. We solicited comments concerning possible acceptable approaches on potential changes to the reclassification

guidelines. We indicated that we would consider all comments received by October 29, 1991 in developing any proposed rulemaking document that we would issue concerning the reclassification guidelines. We noted that this process would not be completed in time to revise the guidelines for the application period for the FY 1993 reclassifications and that any revisions in the guidelines would be effective no earlier than FY 1994 reclassifications (for which the application period ends October 1, 1992).

We also indicated that any revisions to the guidelines would need to be considered in conjunction with potential changes to labor market definitions. HCFA as well as ProPAC is evaluating alternative methods for defining labor market areas, and refinements could be implemented as early as FY 1994. Thus, it is possible that MGRB reclassification decisions based on revised guidelines could be implemented at the same time refined labor market areas are established.

B. Discussion of Comments

In response to our request in the August 30, 1991 final rule, for comments concerning the MGRB guidelines, we received 134 letters by the October 29, 1991 deadline. Few of the comments dealt with the specifics of the guidelines; instead, most offered general comments on the merits of geographic reclassifications. For example, we received 106 similar letters from reclassified rural hospitals in support of the reclassification guidelines. The commenters stated that the guidelines were fair and equitable; that HCFA should refrain from making any changes until the impact of the prospective payment system for capital-related costs could be evaluated; that Congress created the MGRB to remedy significant payment inequality in the prospective payment system; and that it was appropriate for urban hospitals to be affected adversely by the reclassifications since they had received relatively higher payments in the past.

In contrast, we received 28 letters from urban hospitals and associations stating the guidelines were too liberal and urging that they be tightened considerably. These commenters suggested eliminating the budget neutrality provision, removing the hold harmless provision that protects rural hospitals from receiving lower payments as a result of geographic reclassifications, and phasing in the reclassifications by paying 50 percent of the increased amount in FY 1992 and the entire amount in FY 1993. Since these proposals would require legislative

changes, we are not addressing them in this document.

One commenter suggested using more recent wage survey data from the cost report instead of the HCFA wage survey. However, as we have previously indicated in response to comments recommending that more current wage data be used (see June 4, 1991 final rule (56 FR 25471)), it is essential to use standard data for the same time period so that the wage comparisons can appropriately reflect labor costs for the same point in time. Hospital payroll data for other than the cost reporting period ending in 1988 would not be audited or otherwise verified and, therefore, cannot be used. However, we note that, beginning in FY 1994, we will be updating the wage index annually based on a revised cost reporting form.

Two commenters suggested that the adjacency requirements should be removed in order to expand the number of hospitals eligible for reclassification and to allow hospitals to be reclassified into the MSA most relevant to the applicant's labor market. However, as we indicated in the June 4, 1991 final rule, in response to comments concerning the adjacency requirement (56 FR 25472), there is ample precedent for requiring that hospitals seeking reclassification to a different geographic area be located in a county that is adjacent (that is, contiguous) to that area. The adjacency requirement is consistent with the way OMB defines urban areas and is also consistent with the provision in section 1886(d)(8)(B) of the Act that allows hospitals in certain rural counties that are adjacent to more than one MSA to be deemed urban for prospective payment purposes. Accordingly, we are proposing no changes to the adjacency requirement.

Also, two commenters asked that we preserve the special access rule for sole community hospitals and rural referral centers. Our proposed changes affecting sole community hospitals and rural referral centers are discussed below, along with other proposed changes, in section IV. C. of this preamble.

C. Proposed Changes to the Regulations

The proposed changes in the reclassification guidelines as based on public comment and our analysis of the FY 1992 reclassifications. Since the effects of reclassifications must be budget neutral, increased payments to one group of hospitals are offset by reduced payments to other groups. Therefore, we must assure both that those hospitals meriting reclassification are afforded proper consideration and that other hospitals are protected from the effects of inappropriate

reclassifications. In addition, a number of issues concerning the reclassification guidelines have arisen that warrant clarification in the regulations.

Accordingly, we are proposing the following changes to the guidelines, which we believe will result in more appropriate reclassifications. The changes would be effective for applications submitted by October 1, 1992 for geographic classifications to be implemented on October 1, 1993 (FY 1994). The proposed changes would not affect reclassifications that would be effective for discharges occurring in FY 1993. Given the 1-year time lag between the effective date of any proposed changes to the MGRB regulations and the effect of these changes on hospital reclassifications, we believe it is essential that the following proposed changes be implemented in time to affect applications that will be processed by the MGRB during FY 1993.

1. General Guidelines—Reclassifications for Individual Hospitals

a. *Reclassification to a Single Geographic Area (§ 412.230(a)(1)).* Section 412.230(a)(1) provides that an individual hospital may seek reclassification to "an adjacent urban or rural area" for purposes of using the other area's standardized amount, wage index, or both. As evidenced by the use of the singular in describing the area to which a hospital could be reclassified (i.e., an adjacent rural or urban area), the intent of this provision is that a hospital may seek reclassification to only one area. There is no provision for a hospital to seek reclassification to more than one area. Nevertheless, because the regulations do not specifically prohibit reclassifications to more than one area, several hospitals have been granted reclassification to two separate areas—one for the wage index and one for the standardized amount.

We do not believe it is appropriate for a hospital to be reclassified to more than one area. The purpose of the MGRB process is to permit hospitals that are disadvantaged by their geographic classification to obtain a more appropriate classification to the area with which they have the most economic interaction. Accordingly, although hospitals may be reclassified either for purpose of the wage index, standardized amount, or both, we did not intend to allow hospitals to qualify for reclassification to one area for its wage index and another area for its standardized amount in those situations where they cannot qualify for

reclassification to one area for both the standardized amount and wage index purposes. Therefore, we are proposing to revise § 412.230(a)(1) to specify that a hospital may seek reclassification to only one area. In situations where a hospital can qualify for the wage index of one area and the standardized amount of another area, the hospital must decide which area it wishes to be reclassified to and must indicate its decision in its application.

b. Individual Urban Hospital Reclassification to a Rural Area (§ 412.230(a)). Section 412.230 sets forth the guidelines "for an individual hospital seeking redesignation to a different rural or urban area." However, there is no provision under the regulations for a hospital to seek reclassification from an urban area to a rural area for purposes of the wage index. In the preamble to the June 4, 1991 final rule (56 FR 25468), under the General Principles section, we specifically listed the various types of permissible reclassifications (that is, rural to urban, urban to urban, and rural to rural). We believe that our intent was clear that a hospital must already be located in a rural area if it is seeking reclassification to "another rural" area or "a different rural" area. However, the MGCRB has approved several requests from urban hospitals for reclassification to rural areas for purposes of the wage index.

The regulations do not provide for such reclassifications, nor do we believe whose reclassifications are appropriate. Although an urban hospital may be located near the border of a rural area, generally that hospital's competitive marketplace is more closely tied to the urban hospitals in its MSA than to the rural hospitals that are dispersed throughout the rural counties in the State. On the other hand, since rural areas are made up of all rural counties in an entire State, for a rural hospital to meet the proximity criteria for reclassification to another rural area, it would have to be located within 35 miles of the State border and, therefore, could be more like rural hospitals in the next State than the rural hospitals in its own State. Accordingly, while we allow a rural hospital to be reclassified to another rural area, we do not believe it is appropriate to allow an urban hospital to be reclassified to a rural area. Therefore, we are revising § 412.230(a)(1) to clarify that the only types of reclassifications that are permissible are rural to urban, urban to urban, and rural to rural reclassifications.

c. Special Access Rule for Rural Referral Centers and Sole Community Hospitals Seeking Reclassification § 412.230(a)(4). Section 1886(d)(10)(D)(i)(III) of the Act requires that the MGCRB guidelines include criteria for considering information provided by a hospital with respect to the effects of the hospital's geographic classification on access to inpatient hospital services for Medicare beneficiaries. Generally, access to care is not an issue except for those areas serviced by rural referral centers and sole community hospitals. Under the special access guidelines at § 412.230(a)(4), we exempt rural referral centers and sole community hospitals from the adjacency and proximity requirements in §§ 412.230(a)(2) and (a)(3). If a rural referral center or sole community hospital can qualify for reclassification on the basis of its wages or costs and is unable to meet the proximity requirements in § 412.230(a)(3), it can apply for reclassification based on the need to provide access to care for Medicare beneficiaries. If the MGCRB finds that the hospital qualifies for reclassification under § 412.230(a)(4), it must be reclassified to the MSA closest to the hospital. Alternatively, a sole community hospital or rural referral center may apply for reclassification under the general proximity criteria in § 412.230(a)(3), in which case the hospital would not be limited to reclassification to the closest urban area.

Consistent with the change we are proposing to § 412.230(a)(1), we are proposing that a sole community hospital or rural referral center may not apply under both the special access rule and the general proximity criteria in order to reclassify to different areas for wage index and standardized amount purposes. In the past, some hospitals have qualified under § 412.230(a)(2) and § 412.230(a)(3) for either the wage index or standardized amount reclassification, and used the special access guidelines at § 412.230(a)(4) to waive the adjacency and proximity requirements and qualify for reclassification to the closest urban area for the other reclassification. Again, the intent of the guidelines is to allow a hospital to seek reclassification to the one area with which it has the most economic interaction, either under the special access rule, if applicable, or under the proximity guidelines.

d. Guidelines for a Hospital Requesting Reclassification for Wage Index Purposes. Currently, under § 412.230(e), a hospital meeting the proximity requirement may be

reclassified for purposes of the wage index if it can demonstrate that its wages are at least 85 percent of the average hourly wage for the area to which it requests reclassification. A hospital that cannot meet the 85 percent standard may nevertheless qualify for reclassification if it can demonstrate that its average hourly wage, when adjusted for occupational mix, is at least 90 percent of the average hourly wage for the area to which it requests reclassification. There are no requirements regarding the relationship between the average hourly wage of the hospital and the average hourly wage of the hospitals in its original labor market area. Using these criteria, the MGCRB reclassified more than 843 hospitals for purposes of their FY 1992 wage index.

In the August 30, 1991 final rule, we stated that we would reexamine the guidelines and propose revisions for future application cycles, if appropriate (56 FR 43202). To assess whether the wage index reclassifications were appropriate, we examined the average hourly wages of the reclassified hospitals and compared them to the average hourly wages for the hospitals in their original labor market area and in the area to which they were reclassified.

In addition, we determined the amount of variation in the average hourly wages among hospitals in the same labor market area. We divided the wages for each hospital in the prospective payment system by the average hourly wage for each hospital's original labor market area. We found that, on average, hospitals have an average hourly wage that is 96 percent of the average hourly wage for their labor market. The average hospital hourly wage is less than the average hourly wage for the area because the latter is hour-weighted and larger hospitals tend to have higher wages. We determined that the national standard deviation was 12 percent. Assuming a normal distribution, 68 percent of hospitals nationwide have an average hourly wage that is at least 84 percent and less than 108 percent of the average hourly wage of the area in which they are located.

The relationship between the average hourly wage of reclassified hospitals and the average hourly wage in their original labor market area is demonstrated by the table below. We found that 36 percent of the reclassified hospitals had wages that were less than 100 percent of wages in the area from which they were reclassified. An additional 35 percent had wages that were less than 108 percent of, or one national standard deviation above, their

old area. An additional 17 percent had wages that were less than 115 percent of their original labor market area.

1992 WAGE INDEX RECLASSIFICATIONS

	Percent of wage index reclassifications	Number of hospitals
Hospitals with wages less than 100% of old wage area	36	242
Wage only		51
Wage and rate		
Hospitals with wages greater than 100% and less than 108% of old wage area	35	216
Wage only		70
Wage and rate		
Hospitals with wages greater than 108% and less than 115% of old wage area	17	120
Wage only		22
Wage and rate		
Hospitals with wages greater than 115% of old wage area	12	76
Wage only		18
Wage and rate		
Total wage reclassifications		615

Note.—Table includes only hospitals for which cost reporting data for FY 1989 are available.

We believe the reclassification process was established to provide a mechanism that would allow hospitals to effect a change in their geographic location only in those situations where hospitals had been clearly disadvantaged by their current classification. As the above analysis demonstrates, however, hospitals may be reclassified under the current wage guidelines even though, as evidenced by the relationship between their average hourly wages and their old wage area, they may not be disadvantaged by remaining in their original labor market area. Based on this analysis of the FY 1992 reclassifications, we are proposing to revise the guidelines to ensure that hospitals are appropriately reclassified.

We believe that a hospital should not be reclassified unless its average hourly wage is significantly out-of-line with the average hourly wages of the area in which it is located and is in line with the average hourly wages of the area to which it requests reclassification. The changes we are proposing reflect this belief that the purpose of the MGRB is to address only those situations in which a hospital is clearly disadvantaged by its wage index value under the existing labor market area definitions. In our view, the reclassification of hospitals whose wages are comparable to those of other hospitals in their labor market area results in a fundamental restructuring of

labor market areas that is more appropriately handled systematically through refinement in the labor market area definitions than on an individual hospital basis through the MGRB process. (As noted above in section IV.A. of this preamble, we are evaluating alternative methods for defining labor market areas, and refinements could be implemented as early as FY 1994.)

Specifically, our proposal would add the requirement that a hospital cannot be reclassified unless its average hourly wage is at least 108 percent of the average hourly wage of the area in which it is located. The 108 percent threshold is based on the average hospital wage as a percentage of its area wage (96 percent) plus one standard deviation (12 percent). Currently, the 85 percent standard for the relationship between the hospital's wages and the average hourly wage of the area to which it requests reclassification (found in § 412.230(a)) approximates the average hospital wage as a percentage of its area wage less one standard deviation. (To be consistent, this proposal would also replace the 85 percent standard with an 84 percent standard (96 percent minus one standard deviation)). Thus, to qualify for a wage index reclassification, a hospital would be required to have an average hourly wage that is more than one national standard deviation above its original labor market area and not less than one national standard deviation below its new labor market area. We estimate that 71 percent of the hospitals that were reclassified in FY 1992 would not have qualified for wage index reclassifications if this guideline had been in effect. This includes 89 percent of the urban hospitals and 86 percent of the rural hospitals that qualified for wage index reclassifications in FY 1992.

We are proposing to adopt this change as an additional standard for wage index reclassifications. We believe it is reasonable and appropriate to require that a hospital's wages be out-of-line with its own area and not merely that its wages be in line with the area to which it seeks to be reclassified. We believe that the 108 percent standard, which takes into account the average variation in average hourly wages within a labor market area, is appropriate.

As noted above, we believe the reclassification process was established to provide a mechanism that would allow hospitals to effect a change in their geographic classification only in those situations where hospitals had been clearly disadvantaged by their current classification. Since a hospital's

wage index value is limited by the average of all the salaries and hours in its labor market area, it could be disadvantaged if it is near the border of that area and incurs labor costs that are significantly above the average for the area, and at the same time must compete with hospitals in another area that has higher wage costs.

Therefore, we believe it is appropriate to require a hospital to demonstrate that it is at least one national standard deviation above the average hourly wage for its labor market area. We believe that this is an accepted statistical measure of variation from a norm. In addition, with respect to the existing requirement that a hospital's wages be at least 85 percent of the average hourly wage for the area to which it requests reclassification, we are proposing to reduce the threshold to 84 percent to provide a consistent normative standard for both required components of the reclassification process. The 84 percent standard is one standard deviation (12 percent) below the average hospital wage as a percentage of its area wage (96 percent).

In proposing this revision to the wage guidelines, we also considered three other options. One alternative guideline we considered was to require that a hospital could not be reclassified unless its average hourly wage was at least as great as the average hourly wage of the area in which it was located. Since the wage index is based on the average hourly wage of the area, a hospital whose average hourly wage is less than the average hourly wage of the area in which it is located is not disadvantaged by its original wage index. To the contrary, the hospital is already receiving a wage index adjustment that more than compensates for its wage levels. Therefore, we believe reclassification for purposes of receiving an even higher adjustment would not be appropriate. Moreover, since the salaries and hours of all hospitals in a given labor market area make up the average hourly wage, it is fully expected that some hospitals will have an average hourly wage that is above the average for that area and some will have an average hourly wage that is below it. For these reasons, we believe it is more appropriate to adopt a guideline that would require a hospital to have an average hourly wage that is out of line with its own labor market area.

A second alternative guideline we considered was to require that a hospital can not be reclassified unless its average hourly wage is at least 115 percent of the average hourly wage of

the area in which it is located. To qualify for a wage reclassification under this option, a hospital would be required to have an average hourly wage that is at least 15 percent above the average hourly wage of the area in which it is located and no more than 15 percent below the average hourly wage of the area to which it requests reclassification. Thus, this option would retain the current 85 percent standard for the relationship between the hospital's wages and the average hourly wage of the area to which it requests reclassification. This option provides a consistent 15 percent "out-of-line" test for both the comparison with a hospital's own labor market area and the area to which it seeks reclassification. While we believe it is reasonable to require a hospital to have an average hourly wage that is out-of-line with other hospitals in its area before it is eligible for reclassification, we believe that the 115 percent requirement may be too stringent and that a more reasonable test would be to require that the hospital's average hourly wage be at least one national standard deviation above the average for its own labor market area.

Finally, we considered proposing no change in the guidelines in FY 1994. While we recognize the adverse impact that the revised guideline would have on hospitals that would no longer qualify for wage index reclassifications, there are other considerations that lead us to reject this option and propose a revised guideline. First, given the budget neutrality provision, we believe we have a responsibility to all hospitals to ensure that only appropriate reclassifications occur. Second, the results of our analysis clearly indicate that a significant number of hospitals are being reclassified that are not disadvantaged by their current wage index. In addition, the FY 1994 wage index will reflect more recent wage data and revised labor market areas. An improved wage index and redefined labor market areas may help mitigate the impact of no longer qualifying for reclassification. In this regard, we anticipate that some rural hospitals will be located in urban areas after the MSAs are revised to reflect the 1990 census.

Accordingly, we are proposing to review the wage index guidelines at § 412.230(e) to specify that a hospital can be reclassified only if its average hourly wage is least 108 percent of the average hourly wage of hospitals in its original labor market area and at least 84 percent of the average hourly wage of the hospitals in the area to which it is seeking reclassification or 90 percent of

the average hourly wage after adjustment for occupational mix. (The 90 percent standard based on occupational mix would remain unchanged.) Although we are proposing to make these changes, we specifically invite comment on the alternative options we considered as well as on our proposal.

We note that the hospital-specific wage data currently supplied to hospitals by HCFA during the application process already reflect the average hourly wage for the hospitals' own labor market area. Therefore, the proposed additional wage criterion would not significantly increase the documentation a hospital must submit to support its application. For purposes of determining whether a hospital meets the 108 percent criterion, the hospital's average hourly wage is included in the average for its labor market area.

While the proposed changes would have a significant effect on the number of hospitals that qualify for wage index reclassifications, we note that these changes would not affect hospital reclassifications until FY 1994, and thus would coincide with the next update to the HCFA wage index and the revised labor market definitions. We believe the use of more recent data in computing the area wage index values, coupled with improved labor market areas, should help to mitigate the impact the proposed changes might have on payments to hospitals, since the wage index will better reflect hospital wage levels within each labor market area.

In addition, our analysis indicates that if the proposed guidelines had been in effect in FY 1992, the urban budget neutrality adjustment would have been 51.6 percent lower. In other words, the urban standardized amount would have been reduced by 0.57 percent instead of 1.1 percent.

e. Guidelines for a Hospital Seeking Reclassification for Purposes of its Standardized Amount. A hospital qualifies for reclassification for purposes of its standardized amount if it can demonstrate that its costs per case are more comparable to the amount the hospital would be paid if it were reclassified than to the amount it is paid under its current classification. Accordingly, in order for a hospital to qualify for reclassification for purposes of its standardized payment amount, § 412.230(d)(2) requires that a hospital demonstrate that its case-mix adjusted cost per discharge is at least equal to its current rate plus 75 percent the difference between that rate and what it would receive if it were reclassified.

We are not proposing a change in the guideline for individual hospital reclassifications for purposes of the standardized amount. As a general principle, we believe that inefficient hospitals should not be rewarded by geographic reclassification. Accordingly, in reviewing the guidelines, we wanted to determine whether the criteria for reclassification for purposes of the standardized amount result in the reclassification of hospitals that have high costs because they are operating inefficiently rather than because they are comparable to the hospitals in the area to which they are seeking reclassification. However, our examination of the characteristics of the hospitals that were reclassified for their standardized amount does not indicate there is a significant incidence of inappropriate reclassifications. Although rural hospitals that were reclassified for only the standardized amount have an average occupancy rate that is nearly 4 percentage points below the mean for rural hospitals (41 percent), rural hospitals that were reclassified for both the standardized amount and the wage index as well as other urban hospitals that were reclassified to large urban areas have average occupancy rates that are comparable to the average urban hospital occupancy rate.

Further, any revision in the guideline for standardized amount reclassifications would have limited impact. Any revised guideline would not take effect before FY 1994, and in FY 1995, under section 1886(b)(3)(B)(i)(x) of the Act, the other urban and rural rates will be merged into a single rate. The large urban rate will be only 1.6 percent larger. These changes will reduce the significance of the standardized amount reclassifications.

Moreover, there is no commonly accepted measure of hospital efficiency that could be used to establish an objective standard for reclassification. As with the other guidelines for reclassification, we believe that an objective standard for efficiency would be necessary to ensure that all hospitals are treated fairly and consistently, to facilitate the application process, and to expedite the determination process for geographic reclassifications. Therefore, we are not proposing a change in the guideline for individual hospital reclassifications for purposes of the standardized amount.

f. Application of Numeric Standards. The regulations at § 412.120(b)(1) specify that in order to qualify for reclassification, an urban hospital must be located "no more than 15 miles" and a rural hospital "no more than 35 miles"

from the adjacent area to which it seeks redesignation. In addition, § 412.230(e) specifies that the average hourly wage of a hospital seeking reclassification must be equal to "at least 85 percent" or, if adjusted for occupational mix, "at least 90 percent" of the average hourly wage of hospitals in the labor market area to which it seeks reclassification. Section 412.232(c) sets forth the same criteria for group reclassifications. We believe the words "no more than" and "at least" clearly describe our intent that these numeric standards represent the maximum and minimum acceptable standards. In other words, we intended that any figure greater than 35 miles (such as 35.4) or any figure less than 90 percent (such as 89.9 percent) would not meet these standards.

In a number of its decisions, the MGCRB has interpreted the regulations at §§ 412.120(b)(1) and 412.230(e) to require the use of standard rounding rules to evaluate the data contained in reclassification applications against the numeric standards contained therein. However, as explained above, we believe that the plain meaning of the current regulations clearly indicates that we did not intend these standards to be subject to the rules of rounding. Moreover, the application of rounding rules is inconsistent with HCFA's past practices and policies governing the application of numeric standards. For example, the Medicare statute establishes a number of numeric standards such as those related to the qualifying criteria for disproportionate share hospital adjustments and special status as Medicare-dependent small rural hospitals. These standards are set forth in the statute as minimum criteria described in terms of whole numbers. In applying these standards, HCFA has consistently precluded rounding in determining whether a hospital qualifies for a special payment status, and Congress has not indicated any contrary intent that would override that interpretation. Accordingly, the Administrator has reversed MGCRB decisions where a hospital's reclassification request had been approved on the basis of rounding to meet the prescribed standards. In order to ensure that this policy is applied consistently throughout the adjudicative process, we are modifying the MGCRB regulations in each section where a numeric standard is set forth to specify that rounding is not permitted.

2. Implementation of FY 1994 Hospital Reclassifications

a. Appropriate Wage Data. As noted above, requests for geographic reclassification by the MGCRB must be

filed by October 1 of the Federal fiscal year preceding the Federal fiscal year for which the reclassification decision would be effective. Thus, a request for reclassification for FY 1994 must be filed by October 1, 1992. The MGCRB will consider the request and makes its determination during FY 1993 and the reclassification becomes effective for FY 1994.

Current regulations at §§ 412.230(e)(2) and 412.232(d)(2) specify that the wage data that hospitals submit in support of their applications for geographic reclassification should be taken from the most recent HCFA hospital wage survey. For applications for reclassification effective either for FY 1992 or 1993, the most recent wage data has been from the HCFA survey covering hospitals with cost reporting periods ending in calendar year 1988. However, section 1886(d)(3)(E) of the Act requires that the hospital wage index be updated annually beginning October 1, 1993. This means that in FY 1994, the wage index will be based on the HCFA wage data covering hospitals with cost reporting periods beginning in FY 1990. However, this data will not be available on October 1, 1992, when the MGCRB begins to consider applications for FY 1994 geographic reclassifications (although it may become available later in FY 1993). To ensure that all hospitals are treated equitably, we believe that the MGCRB should base its determinations on the wage data that are in effect for prospective payment purposes during the fiscal year in which the MGCRB makes its decision, even if more recent wage survey data becomes available during that time period. This policy is necessary because the wage data will be submitted throughout the year as part of the HCRIS system and are subject to change as additional cost reports are submitted and the status of the cost reports change from "as submitted" to "settled." The comparison of a hospital's average hourly wage to that of other hospitals is subject to change until the final wage index is issued around each September 1 for the coming fiscal year. We note that while some hospitals would benefit from the updated data, other hospitals would benefit from a delay in using the updated data.

Therefore, we are proposing to revise §§ 412.230(e)(2) and 412.232(d)(2) to clarify that the appropriate wage data are the data used to construct the wage index in effect for prospective payment purposes during the year in which the MGCRB considers the applications. Because the wage data will be updated annually beginning in FY 1994, there will

always be a 1-year lag between the wage data used by the MGCRB to make its determinations and the data used to develop the wage index in effect during the year reclassification is effective.

b. Revised Labor Market Areas. As noted in section III.E. of this preamble, in FY 1994 we expect to implement revised MSA definitions based on the 1990 census data. The revised labor market areas that will be effective for FY 1994 will be based on the new MSA definitions that will be announced by OMB later this year, as well as any refinements in the labor market area definitions that our analysis indicates would be appropriate. As in the past, we anticipate significant changes to the MSA definitions, including the creation, elimination, or merging of MSAs, as well as the movement of counties from one MSA to another.

OMB is not expected to publish revised MSA definitions until later this year, by which time most or all hospitals may have already submitted their applications for FY 1994 reclassification. Even if the revised MSA definitions were to be published in time for some hospitals to submit new or revised requests for reclassification, it would not be equitable or administratively feasible for the MGCRB to use two different sets of MSA definitions in making its determinations on reclassification requests. For example, if an MSA is revised to comprise different counties, the average hourly wage for that area would also change. This could affect a hospital's eligibility for reclassification. It will not be administratively feasible for us to develop a new wage index based on the reconfigured MSAs in time for the MGCRB to take the revised labor market areas into account in considering applications during FY 1993. In addition, a hospital's ability to meet the proximity guidelines may be affected by the new MSAs. To be consistent and equitable to all hospitals, hospitals that are applying for geographic reclassification effective in FY 1994 will need to base their requests on the current MSA definitions, and the MGCRB will make its determinations during FY 1993 based on the MSA definitions used for prospective payment purposes in FY 1993.

In constructing the FY 1994 wage index, it will be necessary for us to group hospitals into their appropriate labor market areas based on the reconfigured MSAs and any other refinements in the labor market area definitions, and to determine where reclassified hospitals should be located and if a reclassification is appropriate.

For example, the revised labor market area definitions could place a rural hospital into a different urban area than the labor market area to which it has been reclassified by the MGCRB. In such a case, it may no longer be to the hospital's advantage to be reclassified into the area to which it requested reclassification. In order to address situations such as these, the proposed rule on the prospective payment system for FY 1994 will provide a detailed discussion of our proposed policies concerning the effects of the new labor market area definitions on the geographic reclassification of hospitals. We note that, as provided in § 412.273(a)(2), a hospital will have 45 days from publication of the FY 1994 proposed rule to withdraw its application for reclassification if it determines that such reclassification would not be advantageous in view of the revised wage data or new labor market areas that will be implemented in FY 1994. The revised MSA definitions will be used by the MGCRB in making determinations for FY 1995 reclassification requests, which must be submitted to the MGCRB by October 1, 1993.

3. Administrative and Procedural Guidelines

a. Withdrawing an Application
 § 412.273. The June 4, 1991 final rule with comment period (56 FR 25458) added § 412.273 to the regulations to provide that a hospital may withdraw an application for reclassification at any time before the MGCRB issues a decision. The regulation further provides that a hospital may withdraw its application following an MGCRB decision provided the request for withdrawal is received within 45 days of HCFA's annual publication of proposed changes to the prospective payment system. However, § 412.273 does not specify to whom a hospital should submit its request for withdrawal. Moreover, although § 412.256(d) sets forth the appeal rights of a hospital that disagrees with a decision of the MGCRB dismissing the hospital's application for reclassification, the regulations do not provide similar appeal rights for a hospital whose request for withdrawal has been denied.

We propose to revise § 412.273 to specify that a hospital's request for withdrawal of an application must be submitted to the MGCRB. Additionally, we propose to add a new paragraph (c) to § 412.273 to provide appeal rights for a hospital whose request for withdrawal has been denied by the MGCRB. We propose that a hospital may request that the Administrator review the MGCRB's

denial within 15 days of the date of the notice of denial. Within 20 days of receipt of the hospital's appeal request, the Administrator will either affirm or reverse the denial.

b. Reopening. Section 1886(d)(10)(C)(iii) of the Act establishes time limits for MGCRB and Administrator decisions to ensure that the effects of reclassification are reflected in the new standardized amounts and wage index values that take effect on October 1 of each year for hospitals under the prospective payment system. Therefore, prompt adjudication by either the MGCRB or the Administrator is essential to ensure that the budget neutrality requirement in section 1886(d)(8)(D) of the Act is met when the annual prospective payment system rates are established.

We have received several requests for reopening of MGCRB decisions after the 15-day appeals period set forth in § 412.276(a), as well as requests for reopening of decisions issued by the Administrator. Section 412.276(a) of the regulations provides that a decision by the MGCRB is final and binding unless the decision is reviewed and changed by the Administrator. Neither the statute nor the regulations gives the MGCRB the authority to reopen its decision. We have considered possible revisions to the MGCRB regulations to provide for reopening. However, due to the statutory deadlines provided in section 1886(d)(10)(C) of the Act, we do not believe that a decision by the MGCRB or the Administrator should be subject to subsequent reopening either on motion of the hospital or the applicable reviewing authority. As noted above, administrative finality is essential under this particular review scheme to achieve budget neutrality. Accordingly, we do not believe it would be appropriate to provide for reopening of decisions, in the same way as provided under § 405.750 or § 405.1885, for decisions by the MGCRB or the Administrator concerning applications for geographic reclassification filed under section 1886(d)(10) of the Act.

We further believe procedures for reopening MGCRB decisions are unnecessary because existing regulations provide ample opportunity for final resolution of issues that may arise in the adjudication of applications for reclassification. For example, hospitals that are dissatisfied with MGCRB decisions concerning their requests for reclassification may appeal those decisions to the Administrator within the time period in § 412.276(a). (As noted above, hospitals would also have the right to appeal both MGCRB

decisions concerning requests to withdraw an application and MGCRB dismissals.) In addition, the Administrator may review a MGCRB decision at his or her discretion within the time period prescribed in § 412.278(c).

We believe that this review process provides sufficient protection for hospitals and HCFA in those instances where a provider or the Administrator believes that a case has been decided incorrectly by the MGCRB. Accordingly, no additional mechanism to revise MGCRB decisions is necessary or appropriate.

However, under § 412.278(f)(4), a decision of the Administrator is not subject to further review. Thus, there are currently no further appeals or reopening rights available to a hospital following a decision by the Administrator. Since the Administrator's review process provides sufficient opportunity to resolve the substantive issues raised by a reclassification application, we do not believe any further review of those issues is warranted. However, given the multiple computations required in adjudicating reclassification applications, we believe that we should provide a brief time period in which the Administrator would have the limited authority to correct inadvertent mathematical or computational errors that would otherwise result in incorrect reclassification. The Administrator would also have the authority to correct a reclassification decision if the evidence that was considered in making the decision clearly shows on its face that an error was made ("facial error").

Examples of mathematical or computational errors include but are not limited to: The erroneous entry of data for the respective cost or wage comparison calculation (for example, transposing figures from the applicable lines of the cost report) or errors due to incorrect mathematical computations. An example of a facial error would be a decision that includes incorrect identifying information for the affected hospital(s), for example, Smith Hospital instead of Smythe Hospital or Waco, Oklahoma instead of Waco, Texas. However, as explained above, substantive issues such as the Administrator's determination to use only wage survey data that has been properly approved and issued for official use by HCFA, or a challenge to the methodology used in determining the respective cost or wage comparison calculation, may not be reviewed during this limited amendment period.

The time period for amending Administrator decisions must be very short to ensure that all reclassification decisions are made in time to be incorporated into the wage index adjustments required by the budget neutrality provisions described above. Accordingly, we are proposing to add a new paragraph (g) to § 412.278 to provide that, within 10 days following a decision issued by the Administrator, a hospital may request that the Administrator amend the decision only to correct mathematical or computational errors, or facial errors. The Administrator would promptly review the hospital's request and amend the decision, if necessary, within 5 days following receipt of the hospital's request for amendment. The Administrator, at his or her discretion, may also amend the decision to correct mathematical, computational, or facial errors within 15 days following the issuance of his or her initial decision. The Administrator's amended decision would be final and would not be subject to judicial review. In accordance with these proposed changes, we also would revise § 412.278(f)(3) to state that the Administrator's decision issued under §§ 412.278 (a) or (c) is final unless it is amended under § 412.278(g).

c. Technical Changes to § 412.278(f)(1). In title 42 of the Code of Federal Regulations, parts 400 to 429, revised as of October 1, 1991, on page 331, the text of § 412.278(f)(1) was printed incorrectly. The correct text, which describes what evidence the Administrator may consider in reviewing an MGRB decision on a hospital's reclassification request, was originally published as § 412.278(c) in our September 6, 1990 interim final rule (55 FR 36770) and was redesignated as § 412.278(f)(1) in our June 4, 1991 final rule with comment period (56 FR 25489). In addition, technical changes to paragraph (f)(1) are needed to clarify that the Administrator may review comments submitted by HCFA or a hospital during the appeals and discretionary review process. These changes should have been included in our June 4, 1991 final rule but were inadvertently omitted.

Accordingly, we are proposing to republish § 412.278(f)(1), with the above-mentioned technical changes, to ensure that this section of the Code of Federal Regulations is correct and to incorporate the necessary references to comments submitted during the appeals and discretionary review process.

V. Other Proposed Changes to the Prospective Payment System for Inpatient Operating Costs

A. Outlier Payments (§ 412.82)

1. Background

Section 1886(d)(5)(A) of the Act requires the Secretary to pay an additional amount beyond the basic prospective payment amount for a hospital inpatient case that involves an extremely long length of stay or extraordinarily high costs to treat when compared to other discharges classified in the same DRG. We refer to these atypical cases as "day outliers" and "cost outliers," respectively. Section 1886(d)(5)(A)(iii) of the Act specifies that outlier payments approximate the marginal cost of care beyond the outlier threshold. The purpose of the outlier payment is to protect the hospital from significant financial loss in individual cases.

In the two final rules published on August 30, 1991 that implemented changes to the inpatient operating prospective payment system and a new prospective payment system for capital-related costs for FY 1992 (56 FR 43196 and 43358, respectively), we established a unified outlier payment methodology for capital and operating outlier cases. Under § 412.82, for day outliers, an additional per diem payment is made for each covered day of care beyond the length of stay threshold. The per diem payment is equal to 60 percent of the average per diem payment (operating and capital) for the DRG, which is calculated by dividing the standard payment for that DRG by the geometric mean length of stay for the DRG. The capital portion of the day outlier payment is multiplied by the applicable Federal transition percentage during the transition to a prospective payment system for capital-related costs.

For cost outliers, we pay 75 percent of charges, adjusted to equal capital and operating costs, beyond the cost outlier threshold. Charges are adjusted to cost using hospital-specific cost-to-charge ratios and standardized to eliminate the effects of the indirect costs of medical education and the costs of treating a disproportionate share of low income patients, for both operating costs and capital-related costs. As with day outliers, the capital portion of the cost outlier payments is then multiplied by the applicable Federal blend percentage. Cases that qualify as both day and cost outliers are paid under the methodology that yields the highest combined capital and operating payment.

The current outlier payment methodology reflects refinements that

we have made since the inception of the prospective payment system to improve the financial protection for high cost cases. In the September 30, 1988 final rule, we refined the payment methodology for day outlier cases that also could qualify as cost outlier cases (53 FR 38502). Previously, our policy was to pay all outlier cases that met the day outlier criteria as day outliers. Our revised policy, as set forth in the September 30, 1988 final rule, is to pay the greater of the day outlier payment amount or the cost outlier payment amount for these cases. This change rectified an inequity in the payment system that resulted in underpaying extremely costly day outlier cases that we would have paid as cost outlier cases except for the fact that they also qualified as day outliers.

In the September 30, 1988 final rule, we also raised the marginal cost factor for cost outliers from 60 to 75 percent in order to target outlier payments to the most costly cases. (As explained below, the marginal cost factor for the burn DRGs is 90 percent.)

We also provided that in determining the cost outlier payment for a case, the hospital's costs would be determined based on hospital-specific cost-to-charge ratios, rather than the national average cost-to-charge ratio used in the original outlier payment policy. The use of hospital specific cost-to-charge ratios enhances the accuracy with which exceptionally costly cases are identified and outlier payments computed, given the wide variation in cost-to-charge ratios across hospitals. This increased accuracy was particularly important given that the types of hospitals that had higher cost-to-charge ratios than the national average (and therefore received lower cost outlier payments using the national ratio rather than the hospital-specific ratio) were the hospitals that performed least well in the early years of the prospective payment system.

In the same final rule, we also implemented changes for the payment of burn outlier cases to reflect section 4008(d)(1)(A) of the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100-203). Section 4008(d)(1)(A) required the Secretary to pay both day and high cost burn outlier cases using a 90 percent marginal cost factor. This provision was effective for discharges occurring on or after April 1, 1988 and before October 1, 1989. We implemented this change in the September 30, 1988 final rule (53 FR 38505). In the September 1, 1989 final rule (54 FR 36479), we explained that we would continue to compute cost outlier burn cases that were discharged on or after October 1, 1989 using the 90

percent marginal cost factor to determine payment, but beginning with discharges occurring on or after October 1, 1989, we would compute payments for day outlier burn cases using the same marginal cost factor of 60 percent used to compute payment for all other types of day outlier cases.

2. Proposed Changes to the Payment Methodology for Day Outliers

In the August 30, 1991 final rule implementing the prospective payment system for hospital inpatient capital-related costs, we stated that, as part of our ongoing study of possible refinements to outlier payment policy, we would examine whether changes in the marginal cost factors used to determine outlier payments would be appropriate in light of the inclusion of capital in the outlier payment (56 FR 43383). The 60 percent figure that was originally used for both day and cost outliers, and is still used for day outliers, was derived from a variety of studies for operating cost payments.³ We believe that the marginal cost factor should be set at a level that is appropriate for Medicare cases, and that is based on more recent data for operating and capital costs.

The RAND Corporation's most recent research for HCFA (under cooperative agreement 99-C-98489/9-08) used FY 1990 MEDPAR data and hospital-specific data from cost reporting periods beginning in FY 1989 (or FY 1988 if the later year was not available) to estimate a Medicare marginal cost factor specifically for day outlier cases.⁴ RAND found that the current methodology of establishing a per diem payment based on 60 percent of the DRG payment divided by the geometric mean length of stay for the DRG exceeds the additional costs of an outlier day by approximately 25 percent. In addition, the data suggest that 38.2 percent of day outlier payments go to cases that are profitable once the outlier payments are included. The incremental cost study that RAND completed for PropAC⁵ indicated that the later days

of a stay have considerably lower costs than the earlier days, for both medical and surgical DRGs. In addition, the average cost per day in the DRGs studied tended to be constant by the 10th day in almost all cases.

RAND's most recent work for HCFA also examined the relation between costs and length of stay. A regression was developed for each DRG with at least 50 day outlier cases in which the cost per case, standardized for the payment adjustments, and including capital costs, was related to the outlier portion of the stay as follows: standardized cost = $a + b \times (\text{LOS} - \text{threshold})$

This form of the regression implies that total costs for the pre-threshold portion of the stay are constant by DRG, and that the incremental cost of outlier days is also a constant. The results indicate a linear relation between total costs and length of stay (LOS). In addition, the incremental costs of an outlier day vary linearly with the ratio of the DRG weight divided by the mean length of stay (either geometric or arithmetic, although the arithmetic mean performs somewhat better). This indicates that the basic form of the per diem payment is appropriate. That is, DRGs with a low ratio of DRG weight to mean length of stay have a lower per diem payment, so the correlation of the low ratio with low incremental costs means that the payment varies appropriately with costs. The geometric mean and the arithmetic mean are very highly correlated ($R^2 = .94$).

RAND then conducted a study of day outlier cases in all DRGs to determine the coefficients in the following equation:

$$\begin{aligned} \text{standardized cost per case} &= a + b \times \\ &((\text{LOS} - \text{threshold}) \times \text{DRG per diem}) \\ \text{where DRG per diem} &= \text{DRG} \\ &\text{weight} \times \text{standardized} \\ &\text{amount} \div \text{mean LOS} \end{aligned}$$

In this case, the estimate of b provides the percent of the DRG per diem payment represented by the incremental cost of an outlier day. RAND found that incremental costs would equal the DRG per diem payment at a factor of approximately 0.54 using the arithmetic mean and 0.39 using the geometric mean. Further, sensitivity analysis indicated that these results are relatively insensitive to modest changes in the cost outlier threshold.

RAND then simulated various day outlier payment policies. All simulations continued to use the geometric mean length of stay for the DRG to determine the day outlier threshold, but tested different ways of calculating the per

diem payment. (The geometric mean is the appropriate mean to use in calculating the day thresholds, because it adjusts for the low tail of the length of stay distribution being truncated at 0, since there are no negative lengths of stay.) The geometric mean is calculated as the antilog of the mean of the log length of stay. Because the logs of two different numbers are closer together than the numbers themselves, the geometric mean compresses the distribution. As a result, day outlier cases have a smaller effect on the geometric mean than they do on the simple average (the arithmetic mean). The arithmetic mean length of stay is therefore larger than the geometric mean length of stay.

In particular, RAND compared current policy to a policy model that used the arithmetic mean length of stay in the computation of the per diem payment, with a marginal cost factor of 0.55.⁶ Under the current policy simulation, 38.2 percent of day outlier payments go to cases that are profitable after the outlier payments are made, while 26.3 percent of total outlier payments go to these cases. Under the simulation using the arithmetic mean and a 0.55 marginal cost factor, only 15.2 percent of outlier payments go to profitable cases.

Using the results of the RAND study, we simulated outlier thresholds and payments using the FY 1991 MEDPAR data to determine the impact of changing the per diem payment calculation across types of outlier cases. We used identical day outlier thresholds, in order to isolate the effects of the change in outlier payment policy, rather than any possible effect of changing the thresholds.⁷

There are four types of outlier cases: cases that qualify only as day outliers, cases that qualify only as cost outliers, cases that qualify under both methodologies ("dual outliers") and are paid as day outliers, and dual outliers that are paid as cost outliers. An optimal outlier policy, in terms of protecting hospitals against financial risk, would

⁶ While the simulation using the arithmetic mean length of stay and a 0.55 marginal cost factor also used a slightly different cost outlier methodology, the impact of the change in cost outlier methodology is negligible on the distribution of outlier payments to profitable cases.

⁷ The thresholds for the current policy simulation were the geometric mean length of stay plus the lesser of 28 days or 3 standard deviations for day outliers for both simulations. For cost outlier payments the thresholds were the greater of 2.0 times the DRG rate or \$34,250 for current law and \$29,750 for the alternative policy simulation. The simulations were done using FY 1991 MEDPAR cases, and FY 1992 payment rates and payment adjustments.

³ Summarized in J. Lipscomb, I. Raskin, and J. Eichenholz, "The Use of Marginal Cost Estimates in Hospital Cost-Containment Policy," *Hospital Cost Containment: Selected Notes for Future Policy*, ed. M. Zubkoff, I. Raskin, and R. Hanft (New York: Prodist, 1978), pp. 527-532.

⁴ A technical paper, Carter, G.M. and Rumpel, J.D., "Payment Rates for Unusual Medicare Hospital Cases," serves as the basis of the following discussion and explains this research in more detail. The paper is available upon request from HCFA.

⁵ Carter, G.M. and Melnick, G.A., "How Services and Costs Vary by Day of Stay for Medicare Hospital Stays," March 1990.

provide equal protection (in terms of the ratio of payments for the case to the costs of the case) across all types of outlier cases. Thus, under an optimal policy, there would be no additional risk

for a hospital that admits one type of outlier case relative to another.

The results of our simulation are presented in the table below. Under current policy, the payment to cost ratios for outlier cases vary from 0.6549

for dual outliers paid as day outliers to 0.4773 for cost only outliers. The modified day outlier policy yields payment to cost ratios varying from 0.5667 to 0.4891 for the same types of cases:

PAYMENT TO COST RATIOS FOR DIFFERENT TYPES OF OUTLIER CASES

Type of payment Outlier case	Current day outlier policy		Revised outlier policy	
	Ratio	Cases	Ratio	Cases
Day only.....	0.5970	81,517	0.5350	70,242
Dual, paid day.....	0.6549	23,617	0.5667	20,580
Dual, paid cost.....	0.5469	32,117	0.5521	46,429
Cost only.....	0.4773	76,924	0.4891	107,913
All outliers.....	0.5426	214,175	0.5215	245,164

¹ Under the alternative policy, we are able to lower the threshold for cost outliers and, as a result, more cases qualify for cost outlier payments than under the current policy (as illustrated by the higher number of outlier cases). Since the additional outlier cases qualify for smaller payments than cases that qualify under the current policy, the ratio of payments to costs is smaller than under the current policy. Yet, total payment for the additional outlier cases would increase under the alternative policy.

In view of the significant potential for improvements in payment equity across types of outlier cases, we are proposing to revise the day outlier payment policy effective for discharges occurring on or after October 1, 1992. Specifically, we are proposing to revise §412.82(c) to reflect that the per diem payment would be calculated using the arithmetic mean and a 0.55 marginal cost factor. That is, the per diem day outlier payment under the prospective payment system for operating costs would be determined by dividing the standard DRG payment by the arithmetic mean length of stay for that DRG, and multiplying the result by 0.55. During the transition to a prospective payment system for capital, the capital portion of the day outlier payment would also be multiplied by the Federal payment blend percentage. (For cost reporting periods beginning in FY 1993, the blend percentage would be 20 percent for fully prospective hospitals, a hospital-specific percentage that reflects the ratio of Medicare inpatient new capital costs to Medicare inpatient total capital for hospitals receiving hold harmless payments, and 100 percent for hospitals receiving 100 percent of the Federal rate.)

The RAND study suggested that the optimal day outlier policy would be to pay only the marginal cost (rather than the full incremental cost) of the additional days of care beyond the threshold. For cost outlier cases, we pay 75 percent of the costs beyond the cost outlier threshold. If we were to adopt this same policy for day outlier cases, the marginal cost factor would be set at .40 (.55 x .75) for day outlier cases. We considered adopting a 2-year phase-in of this policy by proposing a .50 marginal cost factor for day outliers in FY 1993 and moving to a .40 marginal cost factor

in FY 1994. However, because of the significant impact this change would have on those hospitals with longer lengths of stay that have more day outlier cases than average, we believe it would be more appropriate to adopt an incremental change to a .55 marginal cost factor in FY 1993 and evaluate its effects before considering additional revisions to the day outlier payment policy. However, we invite public comments on adopting this optimal policy.

The proposed change in the payment policy for day outliers would provide better protection against costly cases for hospitals, while maintaining a more appropriate level of payments for cases with extraordinarily long lengths of stay that are not also extraordinarily costly. In particular, we believe that this change would ensure that we pay hospitals for day outlier cases no more than the cost of care during the outlier portion of the stay, thus reducing the number of outlier cases that are profitable. While we expect that many outlier cases will move from the day outlier payment methodology to the cost outlier payment methodology based on this proposed change, our analysis indicates that many day-only outlier cases will remain profitable.

We note that the arithmetic mean for the proposed FY 1993 DRGs is set forth in Table 7b.

3. Analysis of the Factors that Affected FY 1991 Outlier Payments

Section 1886(d)(5)(A)(iv) of the Act requires that the total amount of additional payments made for outliers for discharges in a fiscal year may not be less than 5 percent nor more than 6 percent of the total payments projected or estimated to be made based on DRG

prospective payment rates for discharges in that year. In establishing the FY 1991 prospective payment system payment rates and outlier thresholds, we used FY 1989 billing data. We estimated that outlier payments would equal 5.1 percent of DRG payments and set the outlier thresholds at the geometric mean length of stay for the DRG plus the lesser of 29 days or three standard deviations of the length of stay for day outliers, and the greater of 2.0 times the DRG rate or \$35,000 for cost outliers. To estimate the outlier payments, we used the FY 1991 final standardized amounts and wage index values as established in the September 4, 1990 final rule (55 FR 35990), and hospital-specific data from 1989 and 1990 (the most recent we had available). ProPAC, in its June 1991 report to Congress, estimated that FY 1991 outlier payments would equal 5.6 percent of total payments (p. 45).

Preliminary analysis of the FY 1991 billing data indicates that actual outlier payments were 4.0 percent of total DRG payments. We estimate that outlier payments will increase between 0.1 and 0.2 percentage points as later billing data become available. The 4.0 percent is based on the ratio of outlier payments to the sum of the standardized amount and outlier payments, exclusive of additional payments for indirect teaching costs and for serving a disproportionate share of low income patients. If the indirect teaching and disproportionate share payments are included in the calculation, the outlier payment percentage is 4.1 percent. The following table compares the outlier cases and payments we estimated in developing the FY 1991 outlier payment policies compared to the actual FY 1991 outlier experience.

Type of outlier case	Outlier payment as percent of standard payment		Outlier cases as percent of total cases	
	Estimated	Actual	Estimated	Actual
Day outliers only.....	1.4	1.2	1.2	0.9
Dual outliers paid as day outliers.....	1.1	0.8	0.8	0.2
Dual outliers paid as cost outliers.....	1.7	1.2	1.2	0.2
Cost outliers only.....	0.9	0.9	0.9	0.4
Total.....	5.1	4.0	4.0	1.7

The difference between estimated and actual FY 1991 outlier payments did not affect the percentage of outlier cases paid as day outlier cases (63 percent in the estimated and 62 percent in the

actual) or the amount of outlier payments made under the day outlier formula (48 percent of payments were made under the day outlier formula, while we estimated that figure at 49

percent). The following table summarizes the effect of the difference between estimated and actual FY 1991 outlier payments on payments and number of cases by type of outlier case:

COMPARISON OF FY 1991 PREDICTED AND ACTUAL OUTLIER CASES AND PAYMENTS

Type of outlier	Percentage of outlier cases		Percentage of outlier payments	
	Estimate	Actual	Estimate	Actual
Meets day threshold only.....	52	52	27	29
Meets day and cost thresholds, paid using day methodology.....	11	10	22	19
Meet day and cost thresholds, paid using cost methodology.....	14	12	34	30
Subtotal—all cases meeting day threshold.....	77	74	83	78
Meets cost threshold only.....	23	26	17	22
Total.....	100	100	100	100

In order to understand why the estimate of FY 1991 outlier payments did not match more closely actual FY 1991 outlier payments, we examined several factors which could have caused the difference between the predicted outlier payments and the actual payments. We conducted this analysis to ensure that our methodology for estimating outlier payments continues to be appropriate, and that the difference in predicted and actual FY 1991 outlier payments was primarily a function of data changes that we could not predict. The possible sources for the difference could be unanticipated changes in covered inpatient hospital charges, the hospital-specific cost-to-charge ratio, and the payment adjustments used to standardize hospital charges, all of which affect cost outlier payments, or changes in the mix of inpatient cases between the FY 1989 MEDPAR data used to estimate FY 1991 outlier cases and the actual FY 1991 cases. Accordingly, we have analyzed these potential sources for the difference.

a. Inflation in Covered Charges. To determine cost outlier payments, we inflate covered hospital inpatient charges. The inflation factor is based on the historical annual rate of increase in covered charges per case after removing the effects of case mix changes.

If the charge inflation factor was too large, we would have overestimated the

costs of cost outlier cases, and would therefore have set the outlier thresholds at a higher level than if we had known the actual lower rate of inflation in covered charges. In estimating FY 1991 covered charges, we used an 11.4 percent annual inflation factor and multiplied the FY 1989 covered charges by 1.241 (1.114×1.114). This was the best estimate of annual charge inflation available at the time we estimated the FY 1991 outlier payments. The 11.4 percent amount had been used previously to estimate outlier payments. Until this year, we have not been able to re-estimate the inflation factor because of the impact of the Catastrophic Coverage Act of 1988 (Pub. L. 100-360) on FY 1989 and FY 1990 claims data. Section 101 of Public Law 100-360 caused covered charges to increase during FY 1989 and FY 1990 in part because of the increased number of covered days of care resulting from the elimination of the limitation on hospital inpatient benefit days under catastrophic coverage. Using those years' data to re-estimate the charge inflation factor would have resulted in an incorrect charge inflation factor. The distortions in covered hospital inpatient charges resulting from the enactment of Public Law 100-360 also prevent us from directly determining the increase in covered charges between FY 1989 and FY 1991. Therefore, we determined the

compounded annual rate of increase between FY 1988 and FY 1991 after removing the effects of case mix changes. To do this, we calculated the average covered charge per discharge for both FY 1988 and FY 1991, and divided by the national average case mix index for each year. We determined that the total increase in charges per case, net of case mix change, was 33.85 percent, or 10.2 percent compounded annually. Based on this analysis, we estimate that charges increased 21.4 percent between FY 1989 and FY 1991, or 10.2 percent annually compared to the 11.4 percent annual inflation factor used to estimate FY 1991 outlier payments. We note that the new charge inflation figure may increase once additional FY 1991 cases are included in the MEDPAR data, since the cases that appear in later updates of the data tend to have higher charges.

b. Cost-to-Charge Ratios. To determine cost outlier payments, we multiply covered charges by a hospital's cost-to-charge ratio. We used the latest cost-to-charge ratios (from 1989 and 1990 hospital specific data) available at the time we estimated FY 1991 outlier payments. It is possible that the cost-to-charge ratios used to estimate the FY 1991 outlier payments were higher than those used to make actual FY 1991 outlier payments. If the cost-to-charge

ratios used to determine estimated FY 1991 outlier payments were higher than the actual FY 1991 cost-to-charge ratios, then the adjusted costs we used to determine cost outlier payments would have been higher than those used to calculate actual outlier payments. Thus, we would have estimated higher outlier payments than if we had used the actual cost-to-charge ratios. The average cost-to-charge ratio we used to estimate FY 1991 outlier payments was 0.6741, while the average cost-to-charge ratio used to compute actual FY 1991 payments was 0.6606. The difference between the two cost-to-charge ratios indicates hospital's charges have been increasing more rapidly than their costs. On average, using the 0.6741 percent cost-to-charge ratio overstated estimated costs by 2.0 percent compared to what costs would have been using the actual cost-to-charge ratios used to make outlier payments in FY 1991.

c. *Payment Adjustments.* To determine cost outlier payments, we standardize a hospital's charges for indirect teaching and disproportionate share adjustments (IME and DSH). Ordinarily, we use the hospital-specific data from the previous year (1989 and 1990 data in this case) to estimate both adjustments. However, because of changes in the disproportionate share formula, we had to compute some disproportionate share adjustment factors using available 1988 hospital cost report data in estimating FY 1991 payments.

If the DSH and IME payment adjustment factors we used to set the FY 1991 thresholds were lower than those used to make FY 1991 payments, we would again overestimate the costs used to determine cost outlier payments, since we divide the charges by a figure of one plus the IME and DSH adjustment factors. Thus, we would have estimated higher outlier payments than if we had used the actual IME and DSH adjustment factors that were used to determine payments. The average DSH adjustment factor we used to estimate FY 1991 outlier payments was 0.0336, while the factor used to determine actual outlier payments averaged 0.0265 for the first quarter of FY 1991 (before the payment formula for large hospitals in urban areas was changed) and 0.0290 for the rest of FY 1991. Since the actual DSH adjustment factors were lower than those we used to estimate FY 1991 outlier payments, our estimate would have understated the FY 1991 costs of hospitals receiving a disproportionate share adjustment.

The IME factor used to estimate FY 1991 outlier payments was 0.0226, while

the average IME adjustment factor used to determine actual payments was 0.0218. Thus, our estimate would have understated the costs of hospitals receiving an indirect teaching adjustment.

We note that while the DSH and IME adjustment factors that are used to determine the additional payments for DSH and IME are subject to retroactive adjustment during the cost report settlement process, there is no retroactive adjustment in the cost outlier payment determination. That is, even if the DSH and IME factors change during the cost report settlement process, there is no retroactive change in the cost outlier determination to take into account the effect the revised DSH and IME factors would have had on the adjusted charges used to determine the cost outlier payment.

d. *Effect of Revised Adjustment Factors.* To test the effects of the charge inflation factor, the cost-to-charge ratios, and the payment adjustment factors, we used the FY 1989 MEDPAR data, a revised charge inflation factor of 10.2 percent, and the cost-to-charge ratio, IME and DSH adjustment factors used to determine actual outlier payments in FY 1991 to determine what thresholds we would have set to yield 5.1 percent outlier payments if this more recent data had been available. To approximate the cost-to-charge ratios and the IME and DSH factors that were used to determine cost outlier payments, we used the factors on the September 30, 1990 provider-specific file to determine outlier payments for discharges occurring on or after October 1, 1990 and before January 1, 1991 and the factors on the March 31, 1991 provider-specific file to determine payments for discharges occurring on or after January 1, 1991. We used these two files because, as stated above, the DSH payment formula changed effective for discharges occurring on or after January 1, 1991. In addition, we used the three sets of standardized amounts and two wage indexes in effect during FY 1991 rather than the standardized amounts and wage index established in the September 4, 1990 final rule. The thresholds we would have established if these data had been available at that time would have been the geometric mean length of stay for the DRG plus the lesser of 28 days or three standard deviations for day outliers, and the greater of 2.0 times the DRG rate or \$32,500 for cost outliers. (The actual FY 1991 thresholds were the geometric mean length of stay for the DRG plus the lesser of 29 days or three standard deviations for day outliers, and the

greater of 2.0 times the DRG rate or \$35,000 for cost outliers.) We then ran the FY 1991 cases through these outlier thresholds, and we determined that the actual FY 1991 outlier payments would have been 4.3 percent of DRG payments. Since all of the payment adjustments were the same in the two runs, the difference between this percent and the 5.1 percent of DRG payments that we estimated must be related to the differences in the cases in the FY 1989 MEDPAR compared to the FY 1991 MEDPAR.

e. *DRG Classification Changes.* In FY 1991, we made significant changes to the DRG classification system that included the establishment of several higher weighted DRGs. By improving the amount of variation in resource costs explained by the DRGs, in setting the FY 1991 outlier payment policy, we were able to lower the outlier thresholds compared to the thresholds that would have been required if we had not made the DRG classification changes.

The DRG classification changes and their effect on FY 1991 aggregate program payments are discussed in Section II.B, above. Our analysis indicates that aggregate payments were one percent higher than they would have been if we had not made the DRG classification changes. The increase is largely attributable to changes in hospital coding practices in response to the DRG changes. The coding improvements also had an effect on actual FY 1991 outlier payments. The following example illustrates how the DRG reclassification changes affected outlier payments.

When comparing the assignment of FY 1991 cases using the FY 1990 and FY 1991 CROUPERS, almost 1,000 cases that would have been in DRG 14 (Specific Cerebrovascular Disorders Except TIA) using the FY 1990 CROUPERS moved to DRG 483 (Tracheostomy Except for Mouth, Larynx, or Pharynx Disorder). The average length of stay for these cases was 51 days, and the average standardized charges were \$88,401. Total payments for these cases can be calculated with the following data:

DRG	DRG weight	Geometric mean length of stay	Day outlier threshold
14	1.2212	7.3	36
483	14.0597	40.0	68

The payments calculated below assume a cost-to-charge ratio of 0.6606 (the average FY 1991 cost-to-charge ratio), and that the hospital is located in

a large urban area. Using the standardized amounts for a large urban area effective for January 1, 1991 and a wage index value of 1.0 (to which the average charges have been standardized), the payments are calculated as follows:

PAYMENT IN DRG 14 COMPARED TO
PAYMENT IN DRG 483

	DRG payment	Outlier payment	Total payment	Outlier percent- age
DRG 14.....	\$4,277	\$17,548	\$21,825	80.4
DRG 483.....	49,245	—	49,245	0

In estimating the FY 1991 outlier payments, we assigned all the cases in the FY 1989 MEDPAR data to the DRG to which the case would be assigned in FY 1991 based on the diagnoses and procedures indicated on the bill. In the above example, the case in DRG 14 would have been reassigned to DRG 483 if the tracheostomy procedure code had been included on the bill. If the case were assigned to DRG 483, the outlier payment simulation to establish the outlier thresholds would have properly included no outlier payment for the case. On the other hand, if the tracheostomy procedure code had not been included on the bill, the case would have continued to be assigned to DRG 14. If the case were assigned to DRG 14, the outlier simulation would have included an outlier payment and a lower standard payment than would actually occur in FY 1991. The simulation would overstate the outlier payment percentage and the outlier thresholds would be set higher than they would be if the case were fully coded. If the case had been an actual FY 1991 case, it would have been fully coded with the tracheostomy procedure code since the presence of the code would affect payment (whereas it did not in FY 1989). As this example illustrates, coding improvements made in response to the DRG classification changes lowers the outlier payments as a percentage of DRG payments in two ways: It lowers outlier payments, and thus lowers the numerator, and increases DRG payments, and thus increases the denominator.

While we believe that the coding improvements had a significant impact on the outlier payment percentage, we are unable to isolate the effects of these changes from other changes in the distribution of cases or from the effects of the elimination of catastrophic coverage. However, we note that as a

result of the DRG classification changes, total program payments are .99 percent higher than they would have been if the reclassification changes had not been made. Thus, while the DRG reclassification changes had the effect of decreasing outlier payments, they also had the effect of increasing total program payments and there was no reduction in aggregate payments in FY 1991.

f. Repeal of Public Law 100-360 and Changes in Length of Stay. The Medicare Catastrophic Coverage Repeal Act of 1989 (Pub. L. 101-234) repealed Public Law 100-360, effective January 1, 1990. Thus, the FY 1989 MEDPAR data included claims that were still covered under the provisions of Public Law 100-360. In estimating the FY 1991 outlier payments, we estimated the effect of catastrophic coverage by comparing the outlier percentage modeled on covered days and charges and on total days and charges using pre-catastrophic billing data and catastrophic billing data. We estimated that outlier payments would be 93 percent of the amounts based on FY 1989 covered days and charges. Therefore, we set the thresholds based on a 5.5 percent outlier percentage (5.1 divided by .93) but reduced the standardized amount by only 5.1 percent. It is possible that we underestimated the effect of catastrophic coverage by using the FY 1989 claims rather than the FY 1991 claims.

Because of catastrophic coverage, we cannot make a direct comparison between the average covered length of stay in FY 1989 and FY 1991 to determine if a change might have affected the number of cases qualifying for day outlier payments. However, we do know that the total average length of stay decreased from 8.548 in FY 1989 to 8.372 in FY 1991. Assuming that in the absence of catastrophic coverage the ratio of covered days to total days would remain constant, the reduction in the total average length of stay implies that there was a reduction in the average length of stay independent of the repeal of catastrophic coverage. This could have reduced the number of cases qualifying for outlier payments.

We note that in making the adjustment for catastrophic coverage in the FY 1991 final rule, we adjusted only our estimate of outlier payments. We did not adjust the estimated number of day outlier cases directly. Therefore, we would expect a reduction in the comparison between estimated day outlier cases and actual day outlier cases. Day outlier cases as a percentage of total cases declined from 1.5 percent

to 1.3 percent. We are unable to isolate the reduction attributable to the elimination of catastrophic coverage from other changes in the average length of stay and the DRG classification changes.

g. Conclusion. All of the differences between the data we used to estimate the FY 1991 outlier thresholds and the actual data used for determining FY outlier payments could not have been predicted at the time of estimation. We note that in past years we have paid out both less and more than the estimated percent of DRG payments, as the following table illustrates:

Fiscal year	Estimate- d outlier payment	Actual outlier pay- ment
1984.....	1.4	1.1
1985.....	2.5	1.7
1986.....	3.75	2.5
1987.....	5.0	4.0
1988.....	5.0	6.7
1989.....	5.1	6.0
1990.....	5.1	5.2
1991.....	5.1	(est.) 4.0

¹ Shortfall due to statutory delay (until May 1, 1986) in the implementation of updated thresholds reflecting decreases in Medicare length of stay.

² Includes additional outlier payments attributable to the Medicare Catastrophic Coverage Act of 1989.

NOTE.—For the first three years of the prospective payment system, estimated payments were expressed as a percentage of total payments, even though outlier payments were made only on the Federal portion of the prospective payment system payments. For FY 1984, the thresholds were set to provide outlier payments equal to 5.7 percent of Federal payments; for FY 1985 and FY 1986, the target was 5.0 percent of Federal payments. Actual figures for FY 1985-1987 are estimates based on cost report data. In addition, the estimated payment for FY 1988 increased to 5.1 percent as the result of changes to payments effective April 1, 1988.

In all cases, we set the outlier thresholds based on the most current data we had available. Accordingly, we do not believe that it is appropriate to make an adjustment in prospective payment system payments to account for the difference between the estimated and actual FY 1991 outlier payments, just as we have not made adjustments in earlier years (see 51 FR 31525; 52 FR 33048; 53 FR 38508; 54 FR 36500; 55 FR 36077; and 56 FR 43227).

Although outlier payments were 4.0 percent of total standard DRG payments (exclusive of DSH and IME) instead of 5.1 percent, there was no reduction in total standard DRG payments between the payment per case estimated in the FY 1991 final rule and the actual FY 1991 total standard payment per case. As the following table illustrates, the lower outlier payments were more than offset by the increase in standardized amount payments.

	FY 1991 payment per case	
	Estimated	Actual
Average standardized amount payment.....	\$4414.13	\$4533.33
Average Outlier Payment.....	237.36	188.81
Total standard DRG payment per case.....	4651.49	4722.14

The average total payment per case increased 1.5 percent over the amount estimated in the FY 1991 final rule. We would expect an increase in the average payment for increases in the case mix index (CMI). The observed CMI increase was 2.5 percent. After removing the increase attributable to the FY 1991 DRG reclassification changes, the net CMI increase is 1.5 percent. Thus, the payment increases attributable to the DRG classification changes offset the payment reductions attributable to lower outlier payments. Moreover, the average payment per case increase of 1.5 percent exceeds our estimate that real case mix change was between 1.0 and 1.25 percent.

Finally, we note that we set the estimated outlier payment percentage at 5.1 percent each year. Thus, the 1.1 percent reduction in outlier payments is not permanent. In contrast, except to the extent the difference between observed and real case mix increase is taken into account in the update factor, the observed CMI increase is built permanently into the payment amounts.

4. FY 1992 Outlier Payments

We anticipate that FY 1992 outlier payments will be less than the 5.1 percent that we estimated when we set the outlier thresholds. The FY 1992 thresholds were set using FY 1990 cases that did not reflect the coding effects of the FY 1991 DRG classification changes. In addition, the first quarter of the FY 1990 data included the effects of catastrophic coverage, for which an adjustment was made in estimating FY 1992 outlier payments. Thus, the considerations involved in estimating the FY 1992 outlier payments and comparing them to a current estimate based on FY 1991 cases and more recent data are similar to those applicable to comparing the estimated FY 1991 outlier payments to the actual outlier payments in that year.

Using the FY 1991 cases and the FY 1992 payment data, we currently estimate that FY 1992 operating outlier payments will be approximately 3.6 percent of FY 1992 total DRG payments, and that FY 1992 capital outlier payments will also be approximately 3.6 percent of capital DRG payments. (If

indirect teaching and disproportionate share payments are included in the calculation, the estimated outlier percentage is 3.7 percent.) The 3.6 percent estimate for FY 1992 is lower than the 4.0 actual outlier percentage for FY 1991 largely because of changes in the payment adjustment factors. The estimate is based on the December 31, 1991 update to the provider-specific file. These data indicate that the payment adjustment factors for DSH and IME have increased relative to the factors used to pay outlier cases in FY 1991 (which were also used to set the FY 1992 thresholds). The increases would have the effect of reducing the hospital's costs in determining cost outlier payments. In addition, the average cost-to-charge ratio has decreased. This would also have the effect of decreasing the hospital's costs. The comparative payment adjustment factors are as follows:

	FY 1992 final rule estimated (3/31/91 update)	FY 1992 current estimate (12/31/91 update)
DSH factor.....	.0349	.0399
IME factor.....	.0492	.0512
Cost-to-charge ratio.....	.6138	.5992

While we estimate that outlier payments for FY 1992 will be lower than expected, we also anticipate that total DRG payments will be higher than expected based on the newer cases that reflect the FY 1991 DRG changes discussed above. Even though our latest estimates of FY 1992 outlier payments indicate that payments will likely fall short of the 5.1 percent outlier pool, for a number of reasons we do not plan to revise the outlier pool or thresholds midway through the current fiscal year to reflect the estimated outlier shortfall.

In accordance with sections 1886(d)(6) and 1886(e)(5)(B) of the Act, we must publish the annual rates for the prospective payment system by September 1 before each fiscal year. The intent of this requirement is to provide hospitals with advanced notice of the prospective payment rates that will be in effect for the upcoming fiscal year. In order to comply with this requirement, all aspects of the rate setting computations must necessarily be made using the latest data available at the time of publication. This is true not only in establishing the outlier pool, but also in forecasting the increase in the hospital market basket, recalibrating the DRG relative weights, and computing the various required budget neutrality adjustments. We do not believe

Congress contemplated that we would revise any one of these estimates based on later data that becomes available midway through the fiscal year, nor do we believe it is appropriate to do so. Although in this instance our outlier estimates were understated, there are also instances where our estimates have been overstated, not just for outlier payments, but for other elements of the prospective payment system as well. For example, our market basket rate of increase forecasts used to establish the standardized amounts have been overstated for the past two years; however, we have not revised those forecasts as later data became available during the year. Moreover, with respect to estimating the outlier payment pool, we believe we have complied with the intent of section 1886(d)(5)(A)(iv) of the Act that we establish the pool based on "projected or estimated" total payments for the fiscal year. Accordingly, we are not revising the current outlier thresholds based on this latest estimate of outlier payments for FY 1992.

We are using the payment adjustment data on the December 31, 1991 provider-specific file and a 10.2 percent charge inflation factor to establish the proposed FY 1993 outlier thresholds. The proposed thresholds, set forth below, are lower than the FY 1992 thresholds in order to restore the outlier payment percentage to 5.1 percent based on the most current available data.

5. FY 1993 Proposed Outlier Thresholds

For FY 1993, we propose to set the day outlier threshold at the geometric mean length of stay for each DRG plus the lesser of 23 days or 3 standard deviations and the cost outlier threshold at the greater of 2.0 times the prospective payment rate for the DRG or \$34,500. The thresholds we would propose if we were not implementing the change in day outlier payment methodology discussed above would be: for day outliers, the geometric mean length of stay for each DRG plus the lesser of 26 days or 3 standard deviations, and for cost outliers, the greater of 2.0 times the prospective payment rate for the DRG or \$38,500.

The proposed thresholds would slightly increase the proportion of outliers paid as cost outliers relative to those paid as day outliers. We estimate 44.7 percent of cases would be paid using the cost outlier methodology and 55.3 percent would be paid using the day outlier methodology, compared to 41.3 percent of cases being paid using the cost outlier methodology without the proposed day outlier payment change. Cases that meet the day outlier

threshold but that would be paid using the cost outlier methodology, because it yields the higher payment, would increase from 14.0 percent to 17.9 percent of all outlier cases under the proposed policy.

Our simulation of FY 1993 outlier payments based on FY 1991 MEDPAR

data indicates that the percentage of outlier cases that would qualify as day outliers is about 73.2 percent under the proposed policy. The cases qualifying as day outliers would receive 75.8 percent of operating outlier payments in FY 1993. An estimated 26.8 percent of outlier cases would be cost only outlier

cases, which would receive about 24.2 percent of operating outlier payments under the proposed policy. The following table illustrates this finding in greater detail:

Type of outlier	Percentage of outlier cases		Percentage of operating outlier payments		Percentage of capital outlier payments		Percentage of total outlier payments	
	Current policy	New policy	Current policy	New policy	Current policy	New policy	Current policy	New policy
Meets day threshold only	47.5	46.2	25.1	18.5	24.7	18.2	25.0	18.4
Meets day and cost thresholds, paid using day methodology	11.2	9.2	20.7	13.7	20.4	13.5	20.6	13.7
Meets day and cost thresholds, paid using cost methodology	14.0	17.9	32.2	43.7	30.9	41.8	32.1	43.5
Meets cost threshold only	27.3	26.8	22.1	24.2	24.0	26.5	22.3	24.4
Subtotal—all cases meeting day threshold	72.7	73.2	77.9	75.8	76.0	73.5	77.7	75.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

When we modeled the combined operating and capital outlier payments, we found that using a common set of thresholds would result in the same percentage of outlier payments for capital-related costs as for operating costs. We estimate the proposed thresholds would result in outlier payments equal to 5.1 percent of operating DRG payments and 5.1 percent of capital payments based on the Federal rate.

The proposed outlier adjustment factors that would be applied to the standardized amounts and the capital Federal rate for FY 1993 are as follows:

Standardized amount		Capital Federal rate
Urban	Rural	
0.944828	0.978085	0.9490

6. Other Changes Concerning Outliers

We propose to remove certain provisions of § 412.82 that are now obsolete. One provision in § 412.82(c) sets forth the factors to be used to compute day outlier payments during the transition period to the prospective payment system for inpatient hospital operating costs. It applied to cost reporting periods beginning before October 1, 1987 and is no longer applicable. We also propose to remove paragraph § 412.82(d). This provision was implemented to conform our regulations to section 4008(d)(1)(A) of Pub. L. 100-203 which directed the Secretary to compute day and high cost outlier payments for burn cases using a marginal cost factor of 90 percent in place of the 60 percent and 75 percent factor we used to calculate day and high cost outlier payments for other types

cases. As explained in section C.1., the statute was effective only for discharges occurring on or after April 1, 1988 and before October 1, 1989. Unlike payments for high cost, burn outliers, we did not continue to use a 90 percent marginal cost factor to compute payments for day outlier burn cases following expiration of the statutory provision. Therefore we are proposing to delete § 412.82(d) since it is no longer applicable in determining day outlier payments.

Table 8a in section IV of the addendum to this proposed rule contains the updated Statewide average operating cost-to-charge ratios for urban hospitals and for rural hospitals to be used in calculating cost outlier payments for those hospitals for which the intermediary is unable to compute a reasonable hospital-specific cost-to-charge ratio. Effective October 1, 1992, these Statewide average ratios replace the ratios published in the August 30, 1991 final rule (56 FR 43196). Table 8b contains comparable Statewide average capital cost-to-charge ratios. We propose that these average ratios would be used to calculate cost outlier payments for those hospitals for which the intermediary computes operating cost-to-charge ratios lower than 0.316374 or greater than 1.27564 and capital cost-to-charge ratios lower than 0.014496 or greater than 0.248882. This range represents 3 standard deviations (plus or minus) from the mean of the log distribution of cost-to-charge ratios for all hospitals. The cost-to-charge ratios in Tables 8a and 8b would be applied to all hospital-specific cost-to-charge ratios based on cost report settlements occurring during FY 1992.

B. Rural Referral Centers (§ 412.96)

Under the authority of section 1886(d)(5)(C)(i) of the Act, § 412.96 sets forth the criteria a hospital must meet in order to receive special treatment under the prospective payment system as a rural referral center (that is, payment is based on the other urban payment rate rather than the rural payment rate). One of the criteria under which a rural hospital may qualify as a referral center is to have 275 or more beds available for use. A rural hospital that does not meet the bed size criterion can qualify as a rural referral center if the hospital meets two mandatory criteria (number of discharges and case-mix index) and at least one of three optional criteria (medical staff, source of inpatients, or volume of referrals). With respect to the two mandatory criteria, a hospital is classified as a rural referral center if its—

- Case-mix index is equal to the lower of the median case-mix index for urban hospitals in its census region, excluding hospitals with approved teaching programs, or the median case-mix index for all urban hospitals nationally; and
- Number of discharges is at least 5,000 discharges per year or, if fewer, the median number of discharges for urban hospitals in the census region in which the hospital is located. (We note that the number of discharges criterion for an osteopathic hospital is at least 3,000 discharges per year.)

1. Case-Mix Index

Section 412.96(c)(1) provides that HCFA will establish updated national and regional case-mix index values in each year's annual notice of prospective payment rates for purposes of

determining rural referral center status. In determining the proposed national and regional case-mix index values, we would follow the same methodology we used in the November 24, 1986 final rule, as set forth in regulations at § 412.96(c)(1)(ii). Therefore, the proposed national case-mix index value includes all urban hospitals nationwide and the proposed regional values are the median values of urban hospitals within each census region, excluding those with approved teaching programs (that is, those hospitals receiving indirect medical education payments as provided in § 412.105).

These values are based on discharges occurring during FY 1991 (October 1, 1990 through September 30, 1991) and include bills posted to HCFA's records through December 1991. Therefore, in addition to meeting other criteria, we are proposing that to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 1992, a hospital's case-mix index value for FY 1991 would have to be at least—

- 1.2791; or
- Equal to the median case-mix index value for urban hospitals (excluding hospitals with approved teaching programs as identified in § 412.105) calculated by HCFA for the census region in which the hospital is located.

The median case-mix values by region are set forth in the table below:

Region	Case-mix index value
1. New England (CT, ME, MA, NH, RI, VT)	1.1789
2. Middle Atlantic (PA, NJ, NY)	1.1865
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.2779
4. East North Central (IL, IN, MI, OH, WI)	1.2099
5. East South Central (AL, KY, MS, TN)	1.2247
6. West North Central (IA, KS, MN, MO, NB, ND, SD)	1.1978
7. West South Central (AR, LA, OK, TX)	1.2766
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.3073
9. Pacific (AK, CA, HI, OR, WA)	1.2761

The above numbers will be revised in the final rule to the extent required if additional bills are received for discharges through September 30, 1991.

For the benefit of hospitals seeking to qualify as referral centers or those wishing to know how their case-mix index value compares to the criteria, we are publishing each hospital's FY 1991 case-mix index values in Table 3c in section IV of the addendum to this proposed rule. In keeping with our policy on discharges, these case-mix

index values are computed based on all Medicare patient discharges subject to DRG-based payment.

2. Discharges

Section 412.96(c)(2)(i) provides that HCFA will set forth the national and regional numbers of discharges in each year's annual notice of prospective payment rates for purposes of determining referral center status. As specified in section 1886(d)(5)(C)(ii)(II) of the Act, the national standard is set at 5,000 discharges. However, we are proposing to update the regional standards. The proposed regional standards are based on discharges for urban hospitals' cost reporting periods that began during FY 1990 (that is, October 1, 1989 through September 30, 1990). That is the latest year for which we have complete discharge data available.

Therefore, in addition to meeting other criteria, we are proposing that to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 1992, the number of discharges a hospital must have for its cost reporting period that began during FY 1991 would have to be at least—

- 5,000; or
- Equal to the median number of discharges for urban hospitals in the census region in which the hospital is located, as indicated in the table below:

Region	Number of discharges
1. New England (CT, ME, MA, NH, RI, VT)	7,236
2. Middle Atlantic (PA, NJ, NY)	8,353
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	7,029
4. East North Central (IL, IN, MI, OH, WI)	6,096
5. East South Central (AL, KY, MS, TN)	5,576
6. West North Central (IA, KS, MN, MO, NB, ND, SD)	5,957
7. West South Central (AR, LA, OK, TX)	5,251
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	7,511
9. Pacific (AK, CA, HI, OR, WA)	5,393

We note that all the regional standard now exceed the national of 5,000. Therefore, 5,000 discharges is now the standard all hospitals will have to meet. We reiterate that to qualify for rural referral center status for cost reporting periods beginning on or after October 1, 1992, an osteopathic hospital's number of discharges for its cost reporting period that began during FY 1991 would have to be at least 3,000.

3. Retention of Referral Center Status

In the August 31, 1984 final rule, we announced that we were instituting a periodic review of the status of hospitals that qualified for a payment adjustment as a referral center (49 FR 34746). That final rule stated that this review would allow us to determine if these hospitals continued to meet the criteria for referral center status. The final rule stated that we would grant referral center status to a hospital for a 3-year period. At the end of the 3 years, we would evaluate a hospital's performance in meeting the criteria for qualifying as a referral center. A hospital would have been required to meet the criteria for at least 2 of those 3 years. If it did, the hospital would retain its referral center status for another 3-year period. If the hospital did not meet the criteria for at least 2 of the 3 years, the hospital's status as a referral center would end with the last day of the third cost reporting period for which it received the referral center payment adjustment.

Before we were able to implement this review, the Omnibus Budget Reconciliation Act of 1986 (Pub. L. 99-509) was enacted on October 21, 1986. Section 9302(d)(2) of Public Law 99-509 stated that any hospital that was classified as a rural referral center on the date of the enactment of that law would continue to be classified as a referral center for cost reporting periods beginning on or after October 1, 1986 and before October 1, 1989. Thus, any hospital that was classified as a referral center as of October 21, 1986 (the date of enactment of Public Law 99-509) was guaranteed this status through its cost reporting period beginning before October 1, 1989.

We again attempted to implement the referral center triennial reviews in 1989. In the May 8, 1989 proposed rule (54 FR 19653) and in the September 1, 1989 final rule (54 FR 36486), we reiterated the review criteria and the methodology that we would follow in performing the reviews. However, since some referral centers had been so classified for more than 3 years, the triennial review would be limited to the hospital's compliance during the last 3 years.

Shortly after implementation of the triennial review procedures on October 1, 1989, Congress enacted the Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239) on December 18, 1989. Section 6003(d) of that Act stated that any hospital that was classified as a referral center as of September 30, 1989, including those so classified as a result of section 9302(d)(2) of Public Law 99-509, would continue to be classified

as a referral center for cost reporting periods beginning on or after October 1, 1989 and before October 1, 1992. In the September 4, 1990 final rule (55 FR 36070), the regulations at § 412.96(g)(2) were revised to reflect this provision. These regulations state that referral center status for those hospitals that do not meet the retention criteria will terminate with the first cost reporting period beginning on or after October 1, 1992.

We believe it is important that the rural referral center benefit be available only to those hospitals that continue to be in compliance with the statutory criteria for designation. Therefore, with the expiration of the requirement of section 6003(d) of Public Law 101-239 on October 1, 1992, we are implementing the retention criteria and methodology specified in § 412.96(f) that we had developed previously. These criteria and methodology were discussed in the June 10, 1985 proposed rule (50 FR 24380), in the September 3, 1985 final rule (50 FR 35676) and in the September 1, 1989 final rule (54 FR 36486).

Basically, to retain status as a referral center, a hospital will have to meet the criteria for classification as a referral center specified in § 412.96 (b)(1) or (b)(2) or (c) for 2 of the last 3 years or it must qualify on the basis of the requirements for the current year. A hospital may meet any one of three sets of the specific criteria for individual years during the 3-year period or the current year. For example, a hospital may meet the two mandatory requirements in § 412.96 (c)(1) (case-mix index) and (c)(2) (number of discharges) and the optional criterion in paragraph (c)(3) (medical staff) during the first year. During the second or third year, the hospital may meet the criteria under § 412.96(b)(1) (rural location and appropriate bed size).

A hospital will have to meet all of the criteria within any applicable section of the regulations in order to meet the retention criteria for a given year. That is, it will have to meet all of the criteria of § 412.96(b)(1) or § 412.96(b)(2) or § 412.96(c). For example, if a hospital meets the case-mix index standards in § 412.96(b)(2) in years 1 and 3 and the number of discharge standards in § 412.96(c)(2) in years 2 and 3, it will not meet the retention criteria. All of the standards would have to be met in the same year.

In accordance with § 412.96(f)(2), the review process will be limited to the hospital's compliance during the last 3 years. Thus, if a hospital meets the criteria for at least 2 of the last 3 years or for the current year the criteria for FY 1993 outlined above in section V.C.1 and

2 of this preamble, it will retain its status for another 3 years. No hospital will be subject to a review until the end of its third full cost reporting period as a referral center. We have constructed the following chart and example to aid hospitals and qualify as referral centers under the criteria in § 412.96(c) in projecting whether they will retain their status as a referral center.

Under § 412.96(f), to qualify for a 3-year extension effective with cost reporting periods beginning in FY 1993, a hospital must meet the mandatory criteria in § 412.96(c) for FY 1993 or it must meet the criteria for 2 of the last 3 years as follows.

For the cost reporting period beginning during FY	Use hospital's case-mix index for FY	Use the discharges for the hospital's cost reporting period beginning during FY	Use numerical standards as published in the Federal Register on
1992	1990	1990	August 30, 1991.
1991	1989	1989	September 4, 1990.
1990	1988	1988	September 1, 1989.

Example: A hospital with a cost reporting period beginning July 1 qualified as a referral center effective July 1, 1988. The hospital has fewer than 275 beds. Its status as a referral center is protected through June 30, 1993 (the end of its cost reporting period beginning July 1, 1992). To determine if the hospital should retain its status as a referral center for an additional 3-year period, we will review its compliance with the applicable criteria for its cost reporting periods beginning July 1, 1990, July 1, 1991, and July 1, 1992. The hospital must meet the criteria either for its cost reporting period beginning July 1, 1993 or for two out of the three past periods. For example, to be found to have met the criteria, at § 412.96(c)(2) for its cost reporting period beginning July 1, 1991, the hospital's case-mix index value during FY 1989 must have equaled or exceeded the lower of the national or the appropriate regional standard as published in the September 4, 1990 final rule. The hospital's total number of discharges during its cost reporting year beginning July 1, 1989 must have equaled or exceeded 5,000 or the regional standard as published in the September 4, 1990 final rule.

For those hospitals that seek to retain referral center status by meeting the criteria of § 412.96 (b)(i) and (b)(1)(ii) (that is, rural location and appropriate bed size (500 or more beds for

discharges occurring before April 1, 1988 and 275 or more beds thereafter)), we will look at the number of beds shown for indirect medical education purposes (as defined at § 412.105(b)) on the hospital's cost report for the appropriate year. We will consider only full cost reporting periods when determining a hospital's status under § 412.96(b)(1)(ii). This definition varies from the bed size criterion used to determine a hospital's initial status as a referral center because we believe it is important for a hospital to demonstrate that it has maintained at least 275 beds throughout its entire cost reporting period, not just for a particular portion of the year.

C. Direct Graduate Medical Education Payment (§ 413.86)

Section 1886(h) of the Act sets forth the provisions governing direct payments for graduate medical education. As implemented by regulations at § 413.86, HCFA pays a hospital a fixed amount per full time equivalent (FTE) resident employed by the hospital. Under § 413.86(f), HCFA determines the number of hospital resident FTEs by applying a weighting factor to each resident.

In order to be given an FTE weight of greater than zero, under § 413.86(h), a foreign medical graduate must pass the Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS), or before July 1, 1986, have received certification from, or passed an examination of the Educational Committee for Foreign Medical Graduates. On or after September 1, 1989, the National Board of Medical Examiners Examination (NBME), parts I and II, may be substituted for the FMGEMS. Failure to meet the qualifying requirements on the part of a foreign medical graduate results in an FTE weight of zero being assigned to that resident. The hospital, as a result, would not receive any direct graduate medical education payments for that resident.

Both the FMGEMS and the NBME are about to be replaced by the United States Medical Licensing Examination (USMLE). Beginning June 1, 1992, foreign medical graduates will have the option of taking the USMLE or the FMGEMS. Effective in July 1, 1993, only the USMLE will be administered, and foreign medical graduates must pass steps I and II in order to receive certification. Therefore, we are proposing to revise § 413.86(h) to reflect this change in the examination requirements.

We note that section 1886(h) of the Act references only the FMGEMS. Therefore, we intend to seek a technical amendment so that the statute will

provide explicitly for recognition of successor tests. We expect the Congress to act on the technical amendment within one year.

VI. Proposed Changes to Capital Prospective Payment System Rules

A. Payments to New Hospitals (§§ 412.300, 412.302, 412.324, and 412.328)

The August 30, 1991 final rule implementing the capital prospective payment system established special payment provisions for new hospitals (56 FR 43418). Under § 412.324(b), a new hospital is paid 85 percent of its allowable Medicare capital-related costs through its cost reporting period ending at least 2 years after the hospital accepts its first patient. Beginning with the third year, the hospital is paid under the fully prospective or hold-harmless payment methodology, as appropriate. If the hospital is paid under the hold-harmless payment methodology, the hospital's hold-harmless payments for its old capital costs continue for up to 8 years.

As defined under § 412.300(b), a new hospital is one that has operated (under previous or present ownership) for less than 2 years and does not have a 12-month cost reporting period that ends on or before December 31, 1990. As a result of situations brought to our attention since the publication of the August 30, 1991 final rule, we are proposing to refine the definition of a new hospital and clarify how we would treat facilities that have operated for more than 2 years but do not have a 12-month cost reporting period ending on or before December 31, 1990. These changes are necessary to ensure that hospitals that actually had an existing asset base on or before December 31, 1990 are not inadvertently provided with an extended transition period and potentially higher payments than other hospitals.

We believe that it is essential to maintain the integrity of the capital prospective payment system by allowing only truly new providers of hospital care to qualify for the new hospital exemption. The exemption is intended to protect hospitals that come under the capital prospective payment system without a historic asset base and need special consideration for their original plant and equipment costs during their initial years of operation. Therefore, we are proposing to clarify that the new hospital exemption under the capital prospective payment system would not apply to a facility that opens as an acute care hospital if that hospital operated in the past under current or previous ownership and has a historic asset base.

Examples of hospitals with an existing asset base that open as acute care hospitals include a hospital that closes and subsequently reopens (under either its original or different ownership), and a facility that changes its certification from a specialty hospital that is excluded from the capital prospective payment system to an acute care hospital. Although a facility may be treated as a new hospital for certification or other payment purposes when it has previously operated as a hospital, it would not qualify for a new hospital exemption under the capital prospective payment system. As is the case with other acute care hospitals, Medicare program payment has been made to the facility in the past under reasonable cost reimbursement rules, either for the same physical assets or for assets that have been replaced, and the hospital had old capital costs as of December 31, 1990. If the facility were permitted to qualify for the new hospital exemption, we would be extending its cut-off date for old capital beyond the date allowed other hospitals with an existing asset base. We believe it is inappropriate to provide the hospital with a special payment protection that is not afforded other hospitals that were in operation before the effective date of the capital prospective payment system. The reasonable cost payment protection under the new hospital exemption should only be available to those hospitals that have not received reasonable cost payments in the past and need special protection during their initial period of operation.

Also, we propose to clarify that a hospital that replaces its entire facility (with or without a change of ownership) does not qualify for a new hospital exemption. Although the hospital may experience a significant change in its asset base, we believe it would be inappropriate to provide the hospital with special payment protection. If we were to allow new facilities built by existing hospitals to qualify for the new hospital exemption, we would provide an inappropriate incentive for hospitals to replace their existing plant instead of renovating or expanding their current facility. If the capital prospective payment system is to be effective in encouraging prudent capital spending, payment must be neutral with respect to decisions concerning whether to renovate or replace existing assets.

Therefore, we are proposing to amend the definition of a new hospital at § 412.300(b) to clarify that the exemption applies only to hospitals that have been in operation for less than 2 years and

does not apply to the following situations:

- A hospital that changes status from an excluded hospital paid under section 1886(b) of the Act to an acute care hospital subject to the provisions of section 1886(d) of the Act.
- A hospital that has been in operation for more than 2 years but has been participating in the Medicare program for less than 2 years.
- A hospital that closes and then reopens under either the same or different ownership.
- A hospital that builds a new or replacement facility at the same or a new location, even if a change in ownership or new leasing arrangements are involved.

Consistent with these changes, we are proposing to revise § 412.328 to clarify that if a hospital (other than a new hospital) does not have a 12-month cost reporting period ending on or before December 31, 1990 as an acute care hospital, the hospital's hospital-specific rate would be based on the hospital's old capital costs per discharge in its first 12-month cost reporting period (or combination of cost reporting periods covering at least 12-months) ending after December 31, 1990. All other transition payment rules apply to the hospital effective with the first cost reporting period that it is subject to the capital prospective payment system.

We are also proposing to clarify the old capital definition applicable to hospitals that qualify for a new hospital exemption. Under § 412.328(a)(2), a new hospital's base period is its 12-month cost reporting period (or combination of cost reporting periods covering at least 12 months) that begins at least 1 year after the hospital accepts its first patient. Although the preamble of the August 30, 1991 final rule (56 FR 43418) stated our intent to treat the hospital's base year costs as old capital costs, the regulations do not explicitly contain this provision. We are proposing to revise § 412.302 to define a new hospital's old capital costs as its allowable capital-related costs for land and depreciable assets that were put in use for patient care on or before the later of December 31, 1990 or the last day of its base period cost reporting period. The limitations in § 412.302(b) that apply to old capital costs would also apply to a new hospital except that the limitations would be based on the hospital's old capital costs for assets that were put in use as of the later of December 31, 1990 or the last day of its base period cost reporting period. We are not proposing any change in the obligated capital provisions with respect to new

hospitals; that is, new hospitals are subject to the same rules on obligated capital as other hospitals (see § 412.302(c)).

B. Portion of Hospital Assets Put in Patient Care Service After December 31, 1990 (§ 412.302)

In the preamble to the August 30, 1991 final rule, we addressed a comment concerning how a situation involving a portion of a hospital that was leased to another party as of December 31, 1990 should be treated if the hospital subsequently takes possession of the space and uses it for patient care (56 FR 43396). We responded to the comment by indicating that the space, which would be a nonreimbursable cost center in the hospital's base year, would be recognized as old capital when it is subsequently used by the hospital for patient care. Although we addressed this specific situation in our response to comments in the final rule, we did not establish a general principle to follow in situations where nonreimbursable cost centers in the base year subsequently become allowable cost centers. We believe that such situations regularly occur in hospital operations and must be specifically addressed in our rules defining old and new capital.

We propose to revise § 412.302(b) to address situations in which a hospital may have a nonreimbursable cost center or otherwise incur unallowable hospital costs for a depreciable asset as of December 31, 1990. Examples of these unallowable costs include costs attributable to space or equipment that is leased to another party or used to provide non-hospital services in part of a building or department that is also used to provide acute care inpatient hospital services. To the extent the costs of such space or equipment become allowable inpatient hospital capital-related costs after December 31, 1990, those costs would be recognized as old capital costs as long as a portion of the asset was in use for hospital inpatient care as of December 31, 1990. The allowable costs that could be recognized as old capital costs would be subject to the current provisions at § 412.302(b). If no portion of an asset was used to provide hospital inpatient care as of December 31, 1990, any allowable hospital inpatient capital-related costs of the asset would be recognized as new capital costs when the asset was returned to hospital inpatient care service.

We considered proposing that any portion of an asset that was not used for patient care as of December 31, 1990, and was subsequently put in use for patient care, would be classified as new

capital. This approach would be consistent with our definition of old capital costs since the nonreimbursable portion of the asset's costs was not an allowable cost as of December 31, 1990 because the asset was not in use for patient care. However, this approach would require that we classify the same asset as old capital with respect to the portion that was in use for patient care as of December 31, 1990, and as new capital with respect to the portion that was in use for nonhospital care as of December 31, 1990. We believe that for purposes of cost finding and the determination of allowable inpatient hospital costs, an individual asset should be considered as either old or new capital, but not both. Therefore, we are proposing that if a portion of an asset was in use for hospital patient care as of December 31, 1990, subject to the limitations in § 412.302(b) on old capital costs, we would recognize as old capital costs any costs for other portions of the asset that subsequently become allowable. If no portion of an asset was in use for hospital patient care as of December 31, 1990, the asset would be classified as new capital if it is subsequently put in use for hospital patient care. We have chosen December 31, 1990 as the cut-off date because the old capital definition implicitly assumes that an asset was put in use on or before December 31, 1990 and continues in use as of December 31, 1990. We do not believe that an asset that was put in use for hospital patient care before December 31, 1990 but was taken out of hospital patient care service by December 31, 1990 should be classified as old capital and receive the same protection under the hold-harmless provision as an asset that was actually in use for hospital patient care as of December 31, 1990.

The proposed policy provides protection for space or equipment costs that are an integral part of assets that otherwise qualify as old capital, while preventing an inappropriate extension of the hold-harmless protections to buildings and equipment that were not used for hospital patient care as of December 31, 1990. We wish to avoid incentives for hospitals to circumvent the capital prospective payment system by converting existing assets that are used to provide nonhospital patient care into hospital assets that would be protected under the hold-harmless methodology while receiving payment under Medicare program benefits for the replacements for the non-hospital assets on a reasonable costs basis. This could occur, for example, if beds in a building used to provide skilled nursing facility

services in a multiple-facility complex were converted to acute care beds and new SNF beds were put in service.

C. Treatment of Old Capital Costs When Hospitals Are Leased After December 31, 1990 (§ 412.302(b))

The August 30, 1991 final rule addressed how various situations involving changes of ownership and sale-and-leaseback transactions are treated under the capital prospective payment system (56 FR 43395 and 43405). Since publication of the final rule, an additional situation has been brought to our attention that merits clarification. When an entire hospital operation is leased without transfer of the asset costs of the previous operator, those asset costs on which the old capital determination was based are no longer the allowable capital-related costs of the hospital. At that time, the new owner's lease costs become the allowable capital-related costs of the hospital. Under § 412.302(b)(3), which limits old capital lease costs to the lease amount obligated as of December 31, 1990, the hospital's lease costs would be new capital. However, in other change of ownership situations occurring after the December 31, 1990 cut-off date for old capital, we allow the old capital determinations applicable to the old owner to continue to apply to the new owner (see 56 FR 43395 and 43405). We believe that it is appropriate to deal with the leasing of the entire facility in a similar manner.

We propose to revise § 412.302(b) to allow continued recognition of the base period old capital cost determinations in situations where a hospital is leased without assumption of the hospital's asset costs. However, we would limit the amount of allowable capital-related costs that could be recognized as old capital to the amount that could be recognized for the same assets in the last cost reporting period before the current operating lease became effective. Any cost above that limitation would be paid for as new capital cost. This policy would affect only those hospitals eligible for capital prospective payments on the basis of the hold-harmless methodology. In those cases, a hospital would not be held harmless for any increased costs resulting from the lease arrangement entered into after December 31, 1990. This approach would be consistent with the general policy of extending the hold-harmless protection only to capital commitments entered into by the December 31, 1990 cut-off date. It would also be consistent with the limitation on the valuation of a new owner's basis in an asset that undergoes

change of ownership, set forth in section 1861(v)(1)(O) of the Act.

For purposes of determining old capital costs, treatment of lease costs that involve leasing of portions of a hospital's operation or assets would continue to be subject to the provisions of § 412.302 (b)(3) and (c)(1)(vi).

D. Obligated Capital Costs (§ 412.302(c))

1. Deadline for Putting Assets in Use

Capital-related costs attributable to assets that are put in use after December 31, 1990 but for which the hospital was obligated as of December 31, 1990 may be recognized as old capital costs under certain conditions. Under the general rule related to contractual obligations (§ 412.302(c)(1)) and the special rule relating to construction-in-progress (§ 412.302(c)(3)), one condition is that the asset be put in use for patient care before October 1, 1994. Under the rule relating to hospitals affected by a lengthy certificate-of-need (CON) process (§ 412.302(c)(2)), the asset must be put in use before the earlier of October 1, 1996 or 4 years from the date the certificate-of-need was approved. Under § 412.302(c)(1)(iv), if a hospital experiences delays due to extraordinary circumstances beyond its control, HCFA may extend the deadline for putting an asset in use to no later than September 30, 1996. Extraordinary circumstances include, but are not limited to, a construction strike or atypically severe weather that significantly delayed completion of a construction project. Normal construction delays do not constitute extraordinary circumstances.

The current regulations do not establish a process for granting an extension in the deadline. We are proposing to require that a hospital requesting an extension of the deadline must notify its intermediary of the extraordinary circumstances that delayed, or will delay, completion of the project beyond the original deadline. The request for an extension must be in writing and filed with the intermediary by the later of January 1, 1993 or within 180 days of the event leading to the delay. The request must describe the circumstances contributing to the delay and explain why they are extraordinary and beyond the hospital's control. The request must also explain why the delay cannot be overcome and must provide a new estimated completion date established by the contractor, supplier, or other servicing party. The intermediary would review and verify the documentation submitted by the hospital. The intermediary would forward the request and the results of its

review to HCFA within 60 days. Unless additional information is required, HCFA would notify the intermediary of its decision on the request within 90 days of receiving the request from the intermediary.

2. Deadline for Notifying Intermediary of Obligated Capital

Section 412.302(c)(1)(v) provides that a hospital must notify its intermediary that it has obligated capital within 90 days of the date the hospital first becomes subject to the capital prospective payment system. The hospital's notification must include documentation establishing that the capital project meets the criteria for recognition as obligated capital and a description of the project and its estimated costs as of December 31, 1990. The intermediary determines whether the applicable criteria are met and notifies the hospital of its decision before the close of the hospital's first cost reporting period under the capital prospective payment system. The intermediary's determination is contingent on the asset being put in use for patient care by the applicable date.

We established the notification and review process for obligated capital for three basic reasons that we still believe are appropriate. First, the old capital cost determination for obligated capital relates to the status of the project and its estimated costs as of December 31, 1990. We believe a prompt submission contemporaneous with when the project was obligated and when the intermediary would be performing base year audits would facilitate both the submission of proper supporting documentation and the determination process. In addition, we want to fix as soon as feasible the amount of obligated capital that will be recognized as the assets are put in use in order to refine the capital acquisition model used for budget neutrality calculations. Finally, we believe that it is appropriate for hospitals to know in advance whether a project will be recognized as old capital and the amount of the limitation on the project costs that will be recognized as old capital costs.

Since the publication of the final capital prospective payment rule, intermediaries and hospital representatives have indicated that although the notification requirement was clearly set forth in the August 30, 1991 final rule (56 FR 43450) and in the interim hospital-specific rate notification letters sent to hospitals at least 30 days prior to their first cost reporting period under the capital prospective payment system, some hospitals did not notify their intermediary of obligated capital

within the required 90 days after the beginning of their first cost reporting period under the capital prospective payment system. Also, since the notification deadline occurs before the end of the third month after a hospital becomes subject to capital prospective payments, some hospitals missed the deadline due to confusion over the distinction between 90 calendar days and a 3-month period.

In view of the shorter timeframe for some hospitals between the publication of the August 30, 1991 final rule and the start of their first cost reporting period under the capital prospective payment system, and to avoid disadvantaging some hospitals that might not have understood the importance of making a timely submission to the intermediary, we have decided to revise § 412.302(c)(1)(v) to extend the deadline for submission of obligated capital cost documentation. We propose to require that a hospital must notify its intermediary of any obligated capital by the later of October 1, 1992 or 90 calendar days after the hospital becomes subject to the capital prospective payment system.

We believe the extension would provide adequate time for all hospitals to familiarize themselves with the requirements for submitting the obligated capital documentation to the intermediary. Also, this action provides a renewed opportunity to submit documentation for hospitals that previously did not submit a notification of obligated capital because of concern about meeting one or more of the qualifying criteria. However, hospitals should be aware that even if they may later meet criteria which they initially anticipated could not be met, there would be no further relief from the notification deadline for submission of obligated capital cost documentation.

Consistent with the extension of the notification deadline for the hospital, we would also extend the deadline for the intermediary's notification to the hospital of its obligated capital determination. We would provide that the intermediary would have 1 year from the date the hospital submits its complete documentation to advise the hospital of its decision.

3. Certificate-of-Need Approvals

Under § 412.302(c)(2), a capital project that is affected by a lengthy certificate-of-need (CON) approval process may qualify as old capital if certain conditions are met. One of the conditions is that the hospital filed the initial CON application on or before December 31, 1989 and had not received

approval as of September 30, 1990. If the hospital received approval no later than September 30, 1990, we believe it is reasonable for the hospital to have entered into a contractual obligation for the project on or before December 31, 1990, in which case the project would qualify under the general rule for obligated capital.

Since the publication of the August 30, 1991 final rule, we have identified situations where the State granted an approval that is conditional upon the hospital fulfilling certain requirements. Since the August 30, 1991 final rule did not describe what would constitute a CON approval, we are proposing to clarify how conditional approvals will be treated under the obligated capital rule.

The conditions in the CON approval may or may not prevent the hospital from proceeding with project activities without delay. For example, a requirement that the hospital obtain adequate financing would not prevent the hospital from entering into a contractual obligation to initiate the project by December 31, 1990. Similarly, conditions related to making minor design modifications would not impede the hospital's ability to proceed with the project. On the other hand, if the hospital received an approval as of September 30, 1990 that was contingent upon a major change in the scope of the project, it would be unreasonable to expect the hospital to enter into a contract for or otherwise proceed with the project by December 31, 1990, since additional planning and design activities may be required.

We propose to amend § 412.302(c)(2)(i)(B) to provide that if a hospital received conditional CON approval for a project, the intermediary would assess the nature of the conditions and determine whether the hospital received sufficient approval for the scope of the project to proceed with the project without undue delay. We believe that the intermediary could best ascertain whether such conditions were sufficient in themselves, given the specific circumstances, to prevent a hospital from proceeding with the project without delay. As is the case with other obligated capital determinations, there would be an internal review process for the intermediary to obtain guidance on questionable cases.

E. Adjusting the Hospital-Specific Rate—Transfer-Adjusted Discharge and Case-Mix Index for Subsequent Base Periods (§§ 412.328(b)(3) and (c)(1))

Section 412.328(b)(3) provides for the determination of a transfer adjustment

factor for each hospital. The transfer adjustment factor is used to adjust the discharge count and the case-mix index used to calculate each hospital's hospital-specific rate. Payment for transfer cases is made on a per diem rate basis, not to exceed the full DRG rate. There is no distortion in the hospital-specific rate if the transfer is paid at the full DRG rate. However, to the extent that a transfer is paid on the per diem rate, the hospital-specific rate would either be understated by counting the transfer as a full discharge, or overstated by excluding the transfer entirely from the discharge count. In developing the August 30, 1991 final rule, we determined that it was not administratively feasible to remove the costs associated with such transfer cases from the allowable capital-related costs in the base period. Instead, we adopted an adjustment to the discharge count to assure that transfers are counted in determining the hospital-specific rate only to the extent that a hospital received a proportionate payment for them. To determine the transfer adjustment factor, we first construct a beneficiary file for a particular cost reporting period from MEDPAR (for the initial base year determinations, the MEDPAR data received as of June 30, 1991). We then count each case as the lower of 1.0 or the result obtained by dividing the length of stay (LOS) for a case by the geometric mean LOS for the case DRG. Thus, a weighted average of the cases represents a proportion of a discharge in each transfer case, not to exceed 1.0. To determine the transfer adjustment factor for each hospital, we then add together the adjusted discharges and divide by total discharges, including transfers.

We also provided in § 412.328(c) for a similar adjustment to the case-mix index for each hospital by multiplying the DRG weight for a transfer case by the ratio of the actual LOS for the case to the geometric mean LOS for the DRG. Using the transfer-adjusted discharge count and case-mix index, we ensured that a hospital's hospital-specific rate would match its costs per discharge.

We provided only for the transfer adjustment factors for the initial base year period in the August 30, 1991 final rule. Therefore, we are proposing to amend §§ 412.328(b)(3) and 412.328(c) to apply appropriately updated transfer adjustment factors for later cost reporting periods that may be used as base periods in the case of a new hospital or a hospital-specific rate redetermination. For later base periods beginning before October 1, 1991, HCFA would determine the discharge transfer adjustment factor for a hospital using

the applicable base period MEDPAR data on file as of the December 31 or June 30 update occurring at least 6 months after the close of the base period involved. Thus, for cost reporting periods ending on or before June 30, 1991 the transfer-adjusted case mix index and discharge transfer adjustment factor in Table 9 would be considered final values. Values for cost reporting periods ending after June 30, 1991 through December 31, 1991 would be published in the final rule. For subsequent periods beginning on or after October 1, 1991, the intermediary for the hospital would determine the discharge transfer adjustment factor for a base period using the most recent billing data available from the Provider Statistical and Reimbursement System as of the date of the final determination of the hospital-specific rate. The transfer-adjusted case-mix index would be determined by using the same data that is used to determine the discharge transfer adjustment factor.

F. Redetermination of the Hospital-Specific Rate (§ 412.328(f))

Section 412.328(f) provides that upon request by a hospital paid under the fully prospective payment methodology, the intermediary redetermines the hospital-specific rate to reflect changes in old capital costs as determined in a cost reporting period beginning subsequent to the base period but no later than the hospital's cost reporting period beginning in FY 1994 (or the cost reporting period beginning after obligated capital that is recognized as old capital is put in use, if later). New capital costs are excluded for the calculation of the revised hospital-specific rate. The revised hospital-specific rate is effective with the beginning of the new base period and continues through the remainder of the transition unless the hospital requests another redetermination. If the revised hospital-specific rate is higher than the Federal rate (after taking into account the estimated effect of outliers and the payment adjustments), the hospital is paid under the hold-harmless methodology effective with the beginning of the new base period.

Section 412.328(f) (as amended by the January 27, 1992 correction notice (57 FR 3016) to the August 30, 1991 final rule) requires that hospital request for a redetermination of the hospital-specific rate must be made not later than 90 days after the close of the hospital's first cost reporting period beginning on or after October 1, 1991, or the cost reporting period that will serve as the new base year, whichever is later.

Since publication of the August 30, 1991 final rule, we have received a number of questions regarding the basic criteria for a hospital-specific rate determination and the process for requesting a redetermination. These questions indicate confusion over when a request for redetermination is appropriate, what responsibilities the hospital has in requesting a redetermination, and whether a hospital is bound by the outcome of the intermediary determination of the revised hospital-specific rate. To help to resolve these issues, we are proposing the following clarifications to the regulations.

We would amend § 412.328(f)(1)(i) to clarify that a redetermination is permitted only when there is an increase in the hospital's old capital costs. We would state explicitly that no redetermination would be made to recognize other conditions that could affect the hospital-specific rate, such as a decline in utilization that produced an increase in the hospital's old capital cost per discharge. As discussed in the preamble to the August 30, 1991 final rule (56 FR 43389), we provided for hospital-specific rate redeterminations as a way of addressing certain situations in which a hospital's base year costs may be sufficiently distorted that they should not be used to determine the hospital's payments throughout the transition period. We selected the redetermination approach over other alternatives since we felt it was most consistent with our decision to provide for limited recognition of obligated capital costs. We believe that a redetermination of the hospital-specific rate based on the hospital's capital cost in the subsequent cost reporting period is a reasonable and appropriate way to take these increases in old capital costs into account for hospitals paid under the fully prospective methodology.

However, we do not believe a redetermination is appropriate when the hospital-specific rate is affected by factors other than an increase in old capital costs. This would include an increase in a hospital's old capital cost per discharge that is solely related to a decline in utilization. We noted in the preamble to the August 30, 1991 final rule that one purpose of moving to a per discharge payment was to enable the Medicare program to provide incentives for efficiency by ending subsidies for underutilized capacity (56 FR 43363). We indicated that building an occupancy adjustment into the hospital-specific rate would undermine the incentives of the prospective payment system.

Further, we noted that we did not believe a redetermination of the hospital-specific rate to reflect fluctuations in occupancy rates was appropriate (56 FR 43412). With regard to special payment protection policies, we noted that although the minimum payment level provides protection against large utilization declines, we explicitly provided that payments would not be made under the extraordinary circumstances exceptions policy for financial losses attributable to declines in patient volume (56 FR 43411). Similarly, it was not our intent to protect hospitals from financial losses attributable to declines in patient volume through the hospital-specific rate redetermination process.

Current regulations provide that a request for redetermination must be made within 90 days of the close of the affected cost reporting period, when the cost report is ordinarily due. We propose to amend § 412.328(f)(1)(iii) to extend the deadline to coincide with the cost report due date and any extension in the cost report filing date granted by the intermediary. We believe revising the regulations to conform with existing administrative practice on the cost report filing deadline is appropriate since the cost report contains essential documentation for redetermining the hospital-specific rate. We note that if the hospital does not file the cost report timely in accordance with the filing date established by the intermediary, the redetermination request must nevertheless be filed timely to receive intermediary consideration.

We believe that hospitals must recognize the significance of requesting a redetermination for increased old capital costs for themselves and for the intermediary who must process the request and make the final hospital-specific rate determination. We wish to avoid unnecessary requests, that is, situations where the redetermined hospital-specific rate would be lower than the hospital's current rate. As a result, we propose to revise § 412.328(f)(1)(iii) so that a hospital requesting a redetermination must submit, along with the cost report for the period it is requesting as its new base year, an estimate indicating that its new hospital-specific rate would be higher than its current rate. In our view, the hospital is an active participant in the redetermination process and thus should not initiate a request unless it has a reasonable expectation of a positive outcome. However, since at the time a redetermination is requested the hospital's current old capital costs have not been audited and the Medicare

statistical data is subject to change, we also propose to amend § 412.328(f)(3) to provide that if the intermediary determines after audit that the new hospital-specific rate is lower, the hospital would be allowed to withdraw its request within 60 days of the intermediary's notification to the hospital of the redetermined rate. This change would protect a hospital that acted responsibly in requesting a redetermination.

G. Effect of Hospital Mergers, Consolidations or Dissolution on the Hospital-Specific Rate (§ 412.331)

In the preamble to the August 30, 1991 final rule, we discussed the appropriate method to determine capital prospective payments when multiple hospitals merge or consolidate during the transition period (56 FR 43405). However, the guidelines set forth in that discussion were not incorporated into the regulations. Also, we did not address situations where a hospital would separate into two or more hospitals after the base period.

Situations involving these types of changes in hospital structure are increasingly being brought to our attention, and we believe that the policies should be incorporated in the regulations. Therefore, we propose to add § 412.331 to incorporate the guidelines provided in the preamble to the final rule of August 30, 1991 for mergers and to establish rules for dealing with situations where a hospital separates into two or more hospitals.

In addition to incorporating the guidelines contained in the August 30, 1991 final rule for consolidation and merger cases, we would clarify that the recalculation of the hospital-specific rate would be applicable only to those cases that meet the previously existing reasonable cost reimbursement rules regarding the criteria for recognizing a merger or consolidation for Medicare program purposes under § 413.134(k). In cases in which the merger or consolidation rules are not met, the transaction involved would simply be treated as a normal asset acquisition for Medicare program purposes. As a result, in situations in which a hospital acquires the assets of another hospital after December 31, 1990, those asset costs would be treated under the rules for determining old capital and new capital costs at § 412.302. Thus, if the transaction occurs after December 31, 1990, the acquired assets and their related capital costs would be considered new capital unless the conditions for recognizing obligated capital assets as old capital under

§ 412.302(c) were met or the provisions for merger and consolidation under our proposed § 412.331 were applicable.

As discussed in the preamble to the August 30, 1991 final rule (56 FR 43405), we would provide that if hospitals merge or consolidate into one hospital after the base year but during the transition period, the hospitals' latest 12-month or longer cost reporting periods ending on or before December 31, 1990 would be combined to determine a discharge-weighted average hospital-specific rate. In addition, we would provide that if, after the base year, a multi-campus hospital splits into two or more separate hospitals that are subject to the capital prospective payment system, the intermediary would determine if the base year capital-related costs and other statistical data for each of the resulting hospitals can be reconstructed from the original hospital's financial and other records. If that data can be determined, the hospital-specific rate for each of the resulting hospitals would be recomputed for the original base year under the current rules. If reconstruction of the necessary data is not feasible, each hospital's hospital-specific rate would be recalculated by establishing the respective hospital's base year as its first 12-month or longer cost reporting period (or combination of cost reporting periods covering at least 12 months) subsequent to the dissolution.

In determining each hospital's old capital costs, the amount that would be recognized as old capital would be limited to the capital-related costs attributable to assets that were in patient care use as of December 31, 1990, and the hospitals would be subject to all other transition period rules. The interim payments for such hospitals would be determined by the intermediary on the basis of the best data available prior to receipt of the new base period cost reports. The final hospital-specific rates would be applied retroactively to the later of the hospitals' first cost reporting period under the capital prospective payment system or the effective date of the dissolution in accordance with § 412.336(c)(2).

H. Extraordinary Circumstances Exceptions Payments (§ 412.348(e))

Section 412.348(e) provides that a hospital may request an additional payment if the hospital incurs an unanticipated capital expenditure in excess of \$5 million (net of insurance proceeds) due to extraordinary circumstances beyond the hospital's control. Extraordinary circumstances include, but are not limited to, a flood, fire, or earthquake. A hospital must

apply to the HCFA Regional Office within 180 days of the extraordinary circumstance causing the unexpected expenditures in order to qualify for exceptions payments. We propose to amend the requirement in § 412.348(e)(2) to acknowledge the possibility that eligible events could occur prior to, or early in, the hospital's first cost reporting period under the capital prospective payment system. Consistent with our proposal to extend the deadline for obligated capital notifications discussed above, we propose to change the deadline for extraordinary circumstances applications to the later of October 1, 1992 or within 180 days of the occurrence of the extraordinary circumstances.

I. Special Payment Protections

1. Hospitals with High Medicare Usage

In response to the February 28, 1991 proposed rule concerning the capital prospective payment system, we received comments urging special payment protection for hospitals with a high Medicare utilization. We responded in the August 30, 1991 final rule (56 FR 43410) that we recognize that hospitals with a high Medicare utilization rate are potentially more at risk financially than hospitals with low Medicare utilization under the capital prospective payment system, since Medicare is their predominant revenue source. At the same time, however, we observed that under the previous capital payment methodology, these hospitals had less incentive than other hospitals to make efficient capital decisions because a higher proportion of their costs were paid by Medicare based on reasonable costs. As a result, we indicated that we would analyze why these hospitals tend to have higher capital costs and examine whether special treatment for high Medicare hospitals might be appropriate under the capital prospective payment system.

In performing the analysis for this proposed rule, we defined high Medicare hospitals as those with a Medicare utilization (Medicare inpatient days divided by total inpatient days) of at least 65.0 percent in both FY 1988 and 1989, as determined using Medicare cost report data. We examined only those hospitals that qualified in both years because Medicare utilization is somewhat volatile, and we wanted to ensure that our analysis concentrated on those hospitals that consistently have a high Medicare utilization.

Although it is clear that hospitals with high Medicare utilization are dependent on Medicare revenues, it is also important to know whether Medicare

beneficiaries are dependent on these hospitals for access to care. To examine this question, we studied the market shares of high Medicare utilization hospitals compared to other hospitals. Market areas are defined as all of those ZIP codes which, when rank-ordered in numerical importance, contribute 75 percent of a hospital's Medicare discharges. The market share of a hospital was then defined as the percentage of Medicare discharges in the hospital's market area that are treated by that hospital. We examined the hospital's market share for all Medicare discharges and for Medicare medical (nonsurgical) discharges. We examined the medical discharges separately to determine if certain groups of Medicare patients were more likely to use high Medicare hospitals. We used discharges from the FY 1988 MEDPAR data.

We compared the market shares of those high Medicare utilization hospitals that were not already subject to special exceptions protection (through their status as sole community hospitals (SCHs) or urban hospitals with at least 100 beds and a DSH patient percentage of at least 20.2 (high DSH) to those hospitals that did not have high Medicare utilization but were afforded the special exceptions protection. In this way, we could determine whether the high Medicare hospitals are more similar to the hospitals afforded special payment protection or to the hospitals in the general exceptions pool. The following table summarizes our market share data (urban or rural location was determined without regard to reclassification by the Medicare Geographic Classification Review Board):

HOSPITAL MEDICARE MARKET SHARES (AS A PERCENT OF MARKET AREA MEDICARE DISCHARGES)

Hospital type	Total discharges	Medical discharges
SCH or high utilization DSH, nonhigh Medicare utilization:		
All.....	.3325	.4108
Urban.....	.2074	.2228
Rural.....	.4989	.6603
High Medicare utilization, non-SCH, and low utilization DSH:		
All.....	.3611	.4863
Urban.....	.2859	.3573
Rural.....	.3965	.5470
Non-high utilization Medicare, non-SCH, and low utilization DSH:		
All.....	.3308	.4074
Urban.....	.2649	.3002

HOSPITAL MEDICARE MARKET SHARES (AS A PERCENT OF MARKET AREA MEDICARE DISCHARGES)—Continued

Hospital type	Total discharges	Medical discharges
Rural.....	4091	5348

The analysis indicates that, while the high Medicare hospitals are dependent on Medicare patients, Medicare patients are not dependent on these hospitals since only 36 percent of Medicare patients residing in their service areas use these hospitals.

The only group of high Medicare utilization, non-SCH, and low utilization DSH hospitals whose market share is significantly higher (in a statistical sense) than the nonhigh Medicare utilization group is urban hospitals with regard only to medical discharges. In addition, the high Medicare utilization, urban hospitals are the only ones that have higher market shares (both total discharges and medical discharges) than SCH and high DSH hospitals. (High Medicare utilization, rural hospitals do have a slightly higher market share for medical discharges.) However, we determined that the high Medicare utilization, urban hospitals treat, on average, 36 percent of the medical discharges and 29 percent of all discharges in their service area. Thus, it appears that there are alternative sources of care available to Medicare beneficiaries that are admitted to high Medicare utilization, urban hospitals.

To determine the effect of high Medicare utilization on capital cost per case, we used the data based on cost reporting periods beginning in FY 1988 and 1989 to run regressions similar to those used in developing the final rule to implement the capital prospective payment system. That is, we used as dependent variables the natural log of Medicare inpatient costs per case, standardized to remove the effects of case-mix index differences. We ran regressions using both total cost per case and capital cost per case. In addition, in the capital regressions, we included age and financing variables in order to eliminate the effects of different age and financing levels on the estimate of the impact of high Medicare utilization on Medicare capital cost per case. The independent variables were:

- The natural log of the hospital wage index based on 1988 wage data.

- The disproportionate share patient percentage for urban hospitals with at least 100 beds.

- Dummy variables for large urban (urban areas with more than 1,000,000 population) and other urban location.

- The ratio of interns and residents to average daily census for teaching hospitals.

- A dummy variable for data used from data from cost reporting periods beginning in FY 1989.

- The natural log of the hospital's occupancy rate.

- Various dummy variables relating to high Medicare utilization status, and large urban, other urban, and rural location of those high Medicare hospitals. These variables do not show the effects of location independent of Medicare utilization, since location is controlled for elsewhere in the equations.

- The capital age and financing variables. These variables include:

- The natural log of the average age of total assets *

- The natural log of the average remaining usable life of total assets *

- The natural log of the ratio of total liabilities to total assets, and

- The natural log of the ratio of total fixed assets to total assets.

First, we ran a regression using capital cost per case, but without the age and financing variables. In this regression, high Medicare utilization, large urban hospitals have higher capital costs per case, everything else being equal, but the coefficient is not statistically significant.

High Medicare utilization hospitals located both in other urban and rural areas have lower capital costs per case, everything else being equal, but only the rural coefficient is statistically significant. The results are summarized below:

CAPITAL COST PER CASE REGRESSION WITHOUT CAPITAL AGE AND FINANCIAL VARIABLES

Type of high Medicare hospital	Coefficient	t-Statistics
Large urban.....	.069	1.505
Other urban.....	-.062	-1.10
Rural.....	-.090	-3.83

* (defined as the ratio of accumulated depreciation to current depreciation)

* (defined as the ratio of remaining depreciation to current depreciation)

Including the age and financing variables in the capital cost regression results in different coefficients and t-statistics, but again, none is statistically significant:

CAPITAL COST PER CASE REGRESSION INCLUDING CAPITAL AGE AND FINANCING VARIABLES

Type of high Medicare hospital	Coefficient	t-Statistic
Large urban.....	.0379	.805
Other urban.....	-.0419	-.771
Rural.....	.0351	1.665

We have found that there is no evidence, once we control for payment adjustments, occupancy, and the capital age and financing variables, that high Medicare utilization hospitals have higher capital costs per case than hospitals with average or low Medicare utilization.

Since the payment adjustments for the prospective payment system for capital-related costs are based on the total cost regressions, we also examined the effects on total cost per case (adjusted for case-mix index) of high Medicare utilization. Again, we controlled for the payment adjustments and for occupancy, to ensure that the only effects that we found in the utilization variables were those of high Medicare utilization. In the equation of total cost per case, the regression coefficients were as follows:

TOTAL COST PER CASE REGRESSION

Type of high Medicare hospital	Coefficient	t-Statistic
Large urban.....	.0294	1.445
Other urban.....	-.0214	-.858
Rural.....	.0170	1.632

Again, none of the coefficients is statistically significant.

The capital cost per case regression results are consistent with the preliminary data on actual payments under the capital prospective payment system. The most recent provider-specific file contains capital data for 44.1 percent of prospective payment hospitals, and 43.3 percent of high Medicare hospitals. The payment methodologies of those hospitals for which we have data are as follows:

PAYMENT METHODOLOGY BY HOSPITAL TYPE

Type of hospital	Number hosps	Fully prospective	Hold harmless	100% Federal rate
All.....	2477	69.5%	17.2%	13.3%
High Medicare.....	197	76.7	15.7	4.8
Urban.....	41	48.8	31.7	19.5
Rural.....	156	84.0	11.5	4.5
Others.....	2280	69.9	17.4	13.8
Urban.....	1109	59.9	21.6	18.6
Rural.....	971	80.6	11.7	7.7

High Medicare utilization, urban hospitals are more likely to receive hold harmless payments than nonhigh Medicare utilization, urban hospitals, but the group of high Medicare utilization, rural hospitals have essentially the same proportion of hold harmless hospitals as other rural hospitals. These data confirm that the group of high Medicare utilization hospitals is not homogeneous, and that the rural hospitals in particular are quite similar to other rural hospitals. We will continue to monitor the payment status of high Medicare utilization hospitals as we receive updated data from the fiscal intermediaries.

Finally, we examined the effect on resource use of having an older Medicare patient population than other

hospitals. Data provided by the Association of High Medicare Hospitals indicate that high Medicare utilization hospitals have a higher proportion of older Medicare patients than do other hospitals. Although older patients tend to have longer lengths of stay, analysis performed at HCFA's request by 3M/Health Information Systems indicates that, on average, older patients require relatively fewer resources than other patients assigned to the same DRG. Since this finding indicates the DRG relative weight tends to overcompensate hospitals that have a higher proportion of older Medicare patients, it does not support a payment adjustment for high Medicare utilization hospitals.

The DRG relative weights are based on the average charge for cases assigned

to the DRG that have been standardized for the hospital wage index and for the payment adjustments for indirect teaching and serving a disproportionate share of low income patients. In its analysis, 3M/Health Information Systems determined for each DRG the average standardized charge by age group and computed the ratio of the age group average standardized charge to the average standardized charge for the DRG. The ratios were separately determined for all patients, and for patients who were discharged alive or who died in the hospital. A discharge-weighted average ratio for each age group across all DRGs was then determined. The results were as follows:

RATIO OF AVERAGE STANDARDIZED CHARGES IN AGE GROUP TO AVERAGE STANDARDIZED CHARGE IN CATEGORY

Age group	Percent of Medicare patients	All discharges	Live discharges	Deaths
<65.....	9.7	1.12357	1.12751	1.31438
65-74.....	41.0	0.98710	0.98377	1.11434
75-84.....	34.7	0.99134	0.98914	0.98374
>84.....	14.6	0.97461	0.98358	0.81954
All patients.....	100.0	1.000	1.000	1.000

Based on our analyses, we do not find any reason to propose a payment adjustment or any special exceptions provisions for high Medicare utilization hospitals at this time. Their Medicare market shares are not appreciably different from those of nonhigh Medicare utilization hospitals. Their capital costs per case, and their total costs per case, are not higher than other hospitals, once the payment adjustments, occupancy and, for capital costs, the age and financing variables are controlled for. Finally, there is no evidence that the older patients that high utilization Medicare hospitals treat require more intensive resource use that would warrant a payment adjustment. We will, however, continue to monitor the characteristics of high Medicare hospitals, particularly once the data on

their capital payment status is completely available.

2. Financially Distressed Hospitals That Serve Low Income Patients

Since the publication of the August 30, 1991 final rule, several organizations representing financially distressed hospitals that serve a large volume of low-income patients have expressed concern that their payments under the capital prospective payment system may be insufficient for the hospitals to obtain the necessary financing to undertake needed capital projects in the future. The organizations note that these hospitals do not have internal reserves that can be used to finance their capital projects and rely heavily on the

Medicare and Medicaid programs for their revenues. If the funding from these sources is not adequate to cover the financing costs, the hospitals will not be able to complete the renovation and construction projects that are needed to preserve access to care for low-income populations. They recommend several changes in the capital prospective payment system policies to address the needs of those hospitals whose projects do not qualify under the obligated capital rules. These include: extending the deadline for putting obligated capital in use in order to be recognized as old capital; paying 85 percent of obligated capital costs for 10 years from the date the asset is put in use instead of ending the hold-harmless payments at the end of the transition; raising the minimum payment floor for hospitals with a high

percentage of low income patients from the 80 percent floor under the current rule to 90 percent and making it, and the extraordinary circumstances exception, permanent; and revising the extraordinary circumstances exception to include major capital projects undertaken by financially distressed hospitals that are needed to preserve access to care by low income populations.

The changes recommended by the organizations representing financially distressed hospitals are similar to suggestions made in the public comments that we considered in developing the August 30, 1991 final rule. We believe it would be premature to modify the policies in that rule until we have had an opportunity to assess their impact. We are sensitive to the needs of these hospitals, and we intend to monitor closely their situation as well as that of other hospitals under the prospective payment system. As we gain additional experience under the capital prospective payment system for capital-related costs, we will be in a better position to evaluate what changes, if any, would be appropriate in our special protection payment policies.

J. Minor Technical Corrections

We propose making the following technical changes to the regulations:

- Section 412.113(a)(2)(E) would be corrected to note that sole community hospitals, as defined in § 412.92, are excluded from the capital payment reduction for periods prior to a hospital's cost reporting period beginning on or after October 1, 1991.
- Section 413.134(f)(2)(iii)(D) would be corrected to change the last reference for capital prospective payment system purposes to § 412.344(a)(2).
- Section 412.302(c)(1)(ii) would be revised to clarify that the qualifying criterion for obligation of moveable equipment is that it was executed on or before December 31, 1990 and obligates the hospital on or before December 31, 1990.

In addition, we are making a series of minor conforming changes throughout 42 CFR parts 412 and 413. These conforming changes are needed to ensure that our regulations specify which provisions apply to the prospective payment system for operating costs, which provisions apply to the prospective payment system for capital-related costs, and which provisions apply to both systems.

VII. Proposed Changes for Hospitals Excluded From the Prospective Payment System

A. Provisionally Excluded Hospitals and Units (§§ 412.22, 412.23, 412.25, 412.30, and 412.32)

1. Changes in the Status of Excluded Hospitals and Psychiatric and Rehabilitation Distinct-Part Hospital Units (§§ 412.22 and 412.25)

Since the inception of the prospective payment system for operating costs of hospital inpatient services on October 1, 1983, certain types of specialty-care hospitals and hospital units have been excluded from that system under section 1886(d)(1)(B) of the Act. These currently include psychiatric and rehabilitation hospitals and distinct part units, children's hospitals, and long-term care hospitals. Section 6004(a)(1) of Public Law 101-239 amended section 1886(d)(1)(B) of the Act to provide that certain cancer hospitals are also excluded. The preamble to the January 3, 1984 final rule implementing the prospective payment system for operating costs (49 FR 235) stated that a hospital's or unit's status (that is, whether it is subject to, or excluded from, the prospective payment system) would be determined at the beginning of each cost reporting period. It also provided that changes in a hospital's or unit's status that result from meeting or failing to meet the criteria for exclusion would be implemented prospectively only at the start of a cost reporting period, that is, starting with the beginning date of the next cost reporting period (49 FR 243). However, this policy is not set forth in the regulations.

Current regulations at § 412.25(b) specify that changes in the bed size or square footage of an excluded unit may be made only at the start of the cost reporting period. However, that regulation does not deal specifically with the case in which an existing hospital changes the function of the unit, adds an entire new unit, or converts an existing excluded unit to an acute care unit paid under the prospective payment system. As a result, questions have arisen as to whether such changes could be allowed at times other than the start of a cost reporting period.

We believe that such changes should not be allowed. Serious cost reporting problems could arise if hospitals were allowed to add new excluded units or to vary the size of existing units, after the start of a cost reporting period. Under Medicare cost-finding principles, certain types of indirect costs of patient care such as capital costs, maintenance of the hospital's physical plant, and

housekeeping expenses, are allocated to a unit solely on the basis of the square footage that unit occupies at the end of the cost reporting period. If, during a cost reporting period, an excluded unit acquires more square footage or a new unit opens, a full year's worth of the indirect costs identified above will be allocated to the unit, even though the unit (or the added space) may have functioned for only a part of the year. If the square footage of a unit decreases during a cost reporting period, some indirect costs associated with the space lost from the unit will not be allocated to the unit, causing unit costs to be understated. In either case, a change during the cost period will cause a misallocation of cost and lead to either excessive or inadequate payments.

To avoid this result, and to clarify our policy in this area, we propose to revise §§ 412.22 and 412.25 to specify that changes in the status of each hospital or hospital unit would be recognized only at the start of a cost reporting period. Except in the case of retroactive payment adjustments for excluded rehabilitation units described in § 412.30(c), any change in a hospital's or unit's compliance with the exclusion criteria that occurs after the start of a cost reporting period would not be taken into account until the start of the following period. This policy would also apply to any unit which is added to a hospital during the hospital's cost reporting period.

For example, if, at some point in a cost reporting period, a currently participating hospital stopped admitting adult patients and began admitting only patients under the age of 18, it could not be excluded from the prospective payment system as a children's hospital before the start of the next cost reporting period. If a currently participating hospital opened a psychiatric unit after a cost reporting period has begun and the unit met the applicable exclusion criteria, services furnished in that unit would be paid for under the prospective payment system for the rest of that period, and the unit would not be excluded from the prospective payment system until the start of the next cost reporting period. If a currently participating hospital had an existing excluded unit and wished to convert the space to acute care use, the change would be recognized only at the start of the next cost reporting period.

In applying this principle to a newly opened unit that is seeking to be excluded from the prospective payment system, we encountered difficulties because existing regulations do not specify when a new unit is considered to

be opened. Questions have arisen as to whether a unit that has no patients at the start of a cost reporting period could be said to open at that time. In order to remove any confusion as to when we consider a unit open, we propose to revise § 412.25(a) to specify that as a requirement for exclusion, a hospital unit must be fully equipped and staffed, and be capable of providing inpatient psychiatric or rehabilitation care, as of the first day of the first cost reporting period for which all other exclusion requirements are met. A unit that meets this requirement would be considered open regardless of whether there are any inpatients in the unit.

2. Exclusion of New Rehabilitation Hospitals and Distinct-Part Rehabilitation Units With Initial Cost Reporting Periods of Less Than 12 Months (§§ 412.23 and 412.30)

Under § 412.23(b)(8), a new rehabilitation hospital may be provisionally excluded from the prospective payment system for its first full 12-month cost reporting period of Medicare participation based on a written certification that the patients it intends to serve meet the criteria for patients needing rehabilitation services set forth in 412.23(b)(2). The regulations, however, do not address the case of a new hospital that begins operating at a time other than at the start of its regular 12-month cost reporting period. Similarly, our regulations at § 412.30 do not specify how a new rehabilitation unit that is a distinct part of a new hospital is to be treated when the hospital begins operations at a time other than at the start of its regular cost reporting period. New hospitals often begin operating at times other than the start of their regular cost reporting periods because of construction delays or other difficulties in starting a new facility. The cost reporting instructions in section 2414.1 of the Medicare Provider Reimbursement Manual allow a new hospital to select an initial cost period of not less than 1 month and not more than 13 months to cover the period between the actual startup date and the beginning of the hospital's preferred 12-month cost reporting cycle.

To avoid requiring a new rehabilitation hospital to operate under the prospective payment system from the date it opens until the beginning of its first full 12-month cost reporting period, we propose to revise § 412.23(b)(8) to permit provisional exclusion of the hospital for both the initial period it may elect under section 2414.1 of the Provider Reimbursement Manual and for the next full 12-month

period. The provisional exclusion would be effective for no more than two consecutive cost reporting periods with a combined total provisional exclusion period not to exceed 25 months.

Under the proposed policy, a separate retroactive adjustment would be made for each cost reporting period during which the hospital is provisionally excluded from the prospective payment system but does not meet the condition that at least 75 percent of the hospital's patients require intensive rehabilitative services (known as the 75-percent rule) set forth in § 412.23(b)(2). During the second cost reporting period of provisional exclusion, the hospital's compliance with the 75-percent rule would be assessed, and the status of the hospital for its third cost reporting period would depend on whether the hospital met the 75-percent requirement for its second cost reporting period.

We propose to revise § 412.30(a) in order to provide similar treatment for rehabilitation units in hospitals that are newly participating in the Medicare program. Under the proposed revision, when a hospital begins participating in the Medicare program and concurrently opens a rehabilitation unit that meets the applicable exclusion criteria, the unit would be provisionally excluded from the prospective payment system from the first day of the hospital's participation through the end of the second cost reporting period. Again, we would specify that the combined total Provisional exclusion period not exceed 25 months. We also propose to revise the regulations to make it clear that a hospital that has undergone a change of ownership or leasing as defined in § 489.18 would be treated as a newly participating hospital for purposes of qualifying for the prospective payment system exclusion, even though the hospital itself is not newly participating because it has previously participated under the old ownership.

3. Removal of Provisions for Excluded Alcohol/Drug Hospitals and Units (§§ 412.23 and 412.32)

Existing regulations at §§ 412.23(c) and 412.32 apply to the exclusion of alcohol/drug hospitals and units. However, as reflected in § 412.32, the exclusion for alcohol/drug hospitals and units ended with cost reporting periods beginning on or after October 1, 1987. Because this exclusion is no longer in effect, we are proposing to delete §§ 412.23(c) and 412.32.

B. Definition of Discharge for Purposes of Applying the Rate-of-Increase Limit Applicable to Excluded Hospitals and Hospital Distinct Part Units (§ 413.40(c))

We are proposing to revise the regulations to include a definition of "discharge" for purposes of applying the rate-of-increase limit applicable to hospitals and hospital distinct part units excluded from the prospective payment system. Section 412.4(a) defines a discharge for purposes of the prospective payment system as any of the following occurrences: the patient is formally released from the hospital, the patient dies in the hospital, or the patient is transferred to a hospital or unit that is excluded from the prospective payment system. There is no definition of discharge specific to the rate-of-increase provision in § 413.40. However, our policy has been that the definition of § 412.4(a) should be followed in applying the rate-of-increase limit.

We are proposing to change that policy to conform to current practice. There are situations in which a Medicare beneficiary has exhausted Medicare benefits during his or her stay and the actual discharge of the patient does not occur until a subsequent cost reporting period. Hospitals excluded from the prospective payment system bill Medicare on an interim basis until the time benefits are exhausted. As a result, the payments and costs of the services are reflected in one cost reporting period but, using the discharge definition in § 412.4(a), the discharge would not be counted until the subsequent cost reporting period. In many cases, since the final discharge bill does not include services covered by the Medicare program beyond those already paid on an interim basis, hospitals do not submit a final bill to Medicare upon the patient's release from the hospital.

To account for benefits-exhausted cases in excluded hospitals and units, the Provider Statistical and Reimbursement System (PS&R), which is designed to capture all statistical and payment data through the claims processing system, has an interface program that counts a discharge when an interim bill is submitted for a beneficiary that has exhausted Medicare benefits, instead of counting a discharge on a no-payment bill that is submitted at discharge. This helps to ensure consistency in the collection of discharge data because hospitals always bill when a patient has exhausted Medicare benefits, but may or may not bill when there are no

Medicare covered services in the final discharge bill. In most cases, the PS&R data are used as cost report settlement statistics, with the result that a discharge is counted for purposes of the rate-of-increase limit when an interim bill is submitted showing benefits are exhausted. This practice provides for agreement between the cost reporting period in which costs are incurred and the application of the rate-of-increase limit. Because the practice of counting a discharge when benefits are exhausted results in a more appropriate discharge count for purposes of the rate-of-increase limit, we are proposing to conform our policy to the current practice. We would revise § 413.40(c)(2) to indicate that a discharge would be defined as set forth in § 412.4(a), except when the beneficiary exhausts Medicare inpatient hospital benefits (including the election to use lifetime reserve days) during the inpatient stay. In that case, the patient would be considered discharged on the date that Medicare benefits are exhausted.

C. New Hospital Exemption Applicable to Excluded Hospitals (§ 413.40 (b), (e), and (f))

Excluded hospitals and units receive payment for the inpatient hospital services they furnish on the basis of reasonable cost, subject to rate-of-increase limits. Under the rate-of-increase limits, an annual target amount (stated as the inpatient operating cost per discharge) is set for each hospital based on the hospital's own cost experience in its base year. This target amount, updated for inflation, is applied as a ceiling on the allowable costs per discharge for the hospital's next cost reporting period.

Under § 413.40 (e) and (f), a new hospital may be exempted from the rate-of-increase limit on its inpatient operating costs if the hospital files a request with its fiscal intermediary within 180 days of receiving the notice of program reimbursement for the hospital's second cost reporting period. (This would be the first cost reporting period for which a hospital is subject to the rate-of-increase limit on its inpatient operating costs.) As specified under § 413.40(f)(1)(i), a new hospital is a provider of hospital inpatient services that has operated as the type of hospital for which HCFA granted it approval to participate in the Medicare program, under present or previous ownership, or both, for less than three full years. The new hospital exemption expires at the end of the first cost reporting period beginning at least two years after the date the hospital admits its first patient. The last cost reporting period for which

the exemption is in effect is the base period for determining the target amount applicable to subsequent cost reporting periods.

We are proposing to make three changes to the provisions of § 413.40(f)(1)(i) concerning new hospital exemptions from the rate-of-increase limit. The first proposed change would make the new hospital exemption automatic rather than at the hospital's discretion. The underlying premise of the rate-of-increase limit is that a hospital's costs are comparable between the base year and the cost reporting periods subject to the limit. The reason for allowing an exemption to the rate-of-increase limit during the early years of a hospital's operations is to recognize that certain cost distortions may be present when a hospital is beginning its operations. Typically, the first year of a hospital's operation is not representative of its future operations² for two reasons. First, the patient load tends to be lower than the load the hospital maintains once it is fully established. Second, the hospital may not immediately offer its full range of services. Since the first year of operation is commonly atypical, we do not believe it would be appropriate to base the target amount on the hospital's inpatient operating costs per discharge for its first year of operation.

Under current regulations, which allow a hospital the option of whether or not to request a new hospital exemption, we in effect allow the hospital to select either its first or third cost reporting period as the base year for its rate-of-increase limit. Since the hospital does not have to file the request for a new hospital exemption until well into its third cost reporting period, the hospital can easily determine which base year would afford it the greater financial advantage. Thus, by having the choice of requesting or foregoing an exemption, a new hospital could obtain a competitive advantage over other hospitals simply because it is a new hospital.

To remedy this situation, we propose to revise § 413.40(f)(1)(i) to apply the exemption automatically to all new hospitals rather than making the exemption contingent on a request from the hospital.

Under current policy, a hospital may be in operation for 3 or more years before it is subject to the rate-of-increase limit. (Cost reporting periods of less than 12 months, which may occur when the hospital begins operation or there is a change of ownership, extend the exemption period beyond 3 years.) We believe that a hospital's second year

of operation should be sufficiently representative to be used to establish the target amount. Therefore, we propose to reduce the new provider exemption to 2 years. A new hospital would be exempt from the rate-of-increase limit through its cost reporting period ending at least 2 years after the hospital accepts its first patient. The base period would be the first 12-month cost reporting period that begins at least 1 year after the hospital accepts its first patient.

Our third proposed change in the new hospital exemption concerns the issue of whether a participating facility that reorganizes and/or changes the basis of its participation in the Medicare program is a new hospital, even though it continues to provide the same services as it did before the reorganization. For example, we are aware of cases in which an acute care hospital had a distinct-part unit (for example, a rehabilitation unit) that eventually split off from the main hospital and became a separate hospital. Under our current regulations, the rehabilitation hospital would meet the criteria for a new hospital and, thus, could qualify for a new hospital exemption.

Another example involved a rehabilitation hospital that added an acute care distinct-part unit. Eventually, the acute-care portion of the facility expanded to a point where the facility sought to participate in the Medicare program as an acute-care hospital with a distinct-part rehabilitation unit. Again, under the current regulations, the distinct-part unit would qualify for an exemption because the hospital technically meets the criteria for a new hospital.

In both examples, the former distinct-part units qualified for a new hospital exemption because they were in existence for less than 3 years as the type of hospital for which they were approved to participate in the Medicare program. However, in a broader sense, these hospitals were not new. As hospitals, they still served the same markets and employed the same staffs as when they operated as distinct-part units. The hospitals in these examples did not have to experience many of the difficulties (such as penetrating new markets or hiring personnel) that are characteristic of a hospital that is beginning its initial operations. Thus, for purposes of establishing rate-of-increase limits on these hospitals' costs, there were no significant cost distortions associated with being a new hospital. Rather, any cost distortions that would affect the comparability of cost reporting periods stemmed from a

change in the organization of the facility's operation rather than in the type of services it provided to patients in the excluded portion of the facility. Therefore, to preclude hospitals from qualifying for a new hospital exemption based solely on such operational reorganizations, we are proposing to revise § 413.40(f) to specify that a hospital will qualify as a new hospital only if it has not previously provided the type of hospital inpatient services for which HCFA granted it approval to participate in the Medicare program.

However, we also recognize that it would not be appropriate to subject these types of hospitals or distinct-part units to the ceiling that applied before the hospital's reorganization. Therefore, when the operational structure of hospital or distinct unit changes (that is, a freestanding rehabilitation hospital becomes a distinct part unit or vice versa), we are proposing to revise § 413.40(b)(1) to clarify that the base period would be the first full 12-month cost reporting period effective with the revised Medicare certification.

We note that the proposed change would mean that the new hospital exemption would not apply to hospitals that change the basis of their certification but do not experience a significant change in organizational structure or in the type of services provided. An example might be a hospital that commenced operations as an acute care hospital subject to the prospective payment system with the intention of qualifying as an excluded long-term care hospital only after its experience demonstrates that the hospital has an average length of stay greater than 25 days. Under current policy, the exemption as a new hospital would begin with the first date of the cost reporting period for which the hospital is certified as a long-term care hospital. Under the revised policy, the exemption would begin with the first day of the cost reporting period in which the hospital began to serve a patient population with an average length of stay greater than 25 days, whether or not the certification is effective for that period. Thus, if the hospital served the requisite population from the outset, the new hospital exemption would be effective as of the date on which the hospital admitted its first patient.

Similarly, a rehabilitation or psychiatric hospital with an average length of stay greater than 25 days may be certified as either a specialty hospital or a long-term care hospital. A hospital that changes its basis of certification while continuing to furnish the same type of specialty services would not

qualify as a new hospital. For example, if a hospital furnishing rehabilitation services to patients with an average length of stay greater than 25 days changed its certification from a rehabilitation hospital to a long-term care hospital, the hospital would not qualify for a new hospital exemption and the original target amount would continue to apply. The proposed policy would be effective for Medicare certifications occurring on or after October 1, 1992.

D. Adjustments Under the Rate-of-Increase Ceiling (§ 413.40(g))

Section 413.40(g)(3) provides that HCFA may make an adjustment to take into account factors that would result in a significant distortion in the operating costs of hospital inpatient services between its base year and the cost reporting period subject to the rate-of-increase ceiling. Section 413.40(g)(3)(ii) was added in the August 30, 1991 final rule to clarify those circumstances under which HCFA may adjust the amount of operating costs in establishing the ceiling without a formal request from a hospital (56 FR 43232). Although this clarification was not intended to limit HCFA's authority to adjust base year costs to only those factors specifically stated in § 413.40(g)(3)(iii), we believe the current regulations could be interpreted to preclude HCFA from making adjustments except under the specified circumstances. However, there may be other cases in which the base period is not a representative base for adjusting future costs. This would include cases in which the hospital had extremely low Medicare utilization during the base period, or cases in which there was a significant change in Medicare coverage during the base year (for example, as a result of the Medicare Catastrophic Coverage Act of 1988). In such cases, the base periods would not be appropriate for establishing a target amount for limiting cost increases in future periods. Therefore, we are proposing to revise § 413.40(g)(3)(iii) to specify the circumstances when HCFA may adjust the amount of operating costs. These circumstances would include, but would not be limited to, adjustments to take into account the factors set forth under § 413.40(g)(3)(ii) (A), (B), (C), (E), and (F).

VIII. ProPAC Recommendations

We have reviewed the March 1, 1992 report submitted by ProPAC to Congress and have given its recommendations careful consideration in conjunction with the proposals set forth in this document. Recommendations 1, 2, and 11 concerning the update factors for

inpatient operating costs are discussed in Appendix D of this proposed rule. The remaining recommendations are discussed below.

A. Updating Capital Payment Rates (Recommendation 3)

Recommendation: ProPAC recommends that a single update factor be developed for adjusting operating and capital prospective payment rates. The update framework should be consistent with that currently used by ProPAC to develop the prospective payment operating rate update recommendation and should be put into use for FY 1994.

Response: In the August 30, 1991 final rule (56 FR 43414), we established the capital update methodology to be used through FY 1995. Under that methodology, we will update the capital Federal rate and the hospital-specific rates for hospitals paid under the fully prospective payment methodology using a lagged 2-year moving average of actual increases in Medicare inpatient capital costs per discharge, adjusted for case mix index change. The capital update proposed in the Addendum to this Federal Register document is based on the average increase in Medicare inpatient capital costs between 1988 and 1990. The capital update established in FY 1995, the last year in which we will use the current methodology, will be based on the average increase in Medicare inpatient capital costs between 1990 and 1992. We established this methodology in response to hospital industry concerns regarding the uncertainty of the capital update over the first few years of the prospective payment system for capital-related costs. We believe that it would be inappropriate to change the method of updating capital payments before FY 1996, because of this desire of the industry for more certainty regarding capital updates.

We believe that it is appropriate to establish a capital-specific update framework until the prospective payment systems for capital-related and operating costs are unified in a single payment system. The development of an update framework for capital payment is conceptually and empirically more difficult than the development of a framework for updating operating payments. For this reason, and in order to solicit comments and to refine our framework, we included a preliminary discussion of an update framework for the capital prospective payment system in the August 30, 1991 final rule implementing the prospective payment system for capital-related costs (56 FR

43522). In the FY 1993 final rule, we will publish a more detailed discussion of the proposed framework, including an empirical illustration of the proposed update framework. This illustration will show the consistency and relationships of the framework with historical trends in operating and capital-related costs through 1990 and with the proposed FY 1993 update. Comments will be solicited on this framework, and we will provide successively improved frameworks in the final rules for FY 1994 and FY 1995. We will continue to solicit comments on these refined frameworks in order to improve the framework that will be adopted for FY 1996. Until this framework is appropriately refined, we believe that using the lagged increase in actual capital costs, adjusted for case-mix index change, is the most reasonable approach to take regarding capital updates.

B. Level of Indirect Medical Education and Disproportionate Share Adjustments to the Prospective Payment System for Operating Payments (Recommendation 4)

Recommendation: ProPAC recommends that the indirect medical education adjustment to the prospective payment system for operating payments be reduced from its current level of 7.7 percent to 7.0 percent for FY 1993. This reduction should be implemented in a budget neutral fashion, with the anticipated decrease in indirect medical education payments returned to teaching hospitals that are designated as disproportionate share providers through a corresponding increase in their disproportionate share adjustment percentages.

Response: ProPAC's recommended reduction of 0.7 percentage points in the operating adjustment for indirect medical education (IME) represents approximately one-third of the difference between the current level of 7.7 percent (set forth at section 1886(d)(5)(B)(ii) of the Act) and 5.7 percent, which is ProPAC's most recent estimate of the effect of teaching activity on inpatient operating costs. That is, ProPAC estimates that for every 10 percent change in the resident-to-bed ratio, there is, on average, a 5.7 percent increase in Medicare inpatient operating costs per case.

ProPAC uses a statistical model to generate its estimate of the effect of teaching on Medicare inpatient operating costs that does not control for the hospital's costs of treating a disproportionate share of low income patients. Controlling for these costs would result in a substantially lower estimate of IME costs because of the

overlap in hospitals receiving IME and disproportionate share (DSH) payments. We believe that it is appropriate to control for the effects of DSH status when estimating the effects of teaching. Not controlling for the effects of all of the payment variables would distort the results of the regressions by attributing some of the effects of the missing variables to the variables present in the regression. We strongly believe that payment for the indirect costs associated with graduate medical education should be based on the best estimate of the added costs incurred in treating Medicare patients and that payments in excess of this amount are an inappropriate use of Medicare trust funds. We further believe, as stated below in our response to ProPAC's Recommendation 5 with respect to the IME adjustment for capital-related costs, that the appropriate level of the IME adjustment is that currently paid in the prospective payment system for capital-related costs. This adjustment is based on regressions on total cost per case, controlling for all of the prospective payment system payment adjustments, including DSH.

ProPAC further recommends that the reduction in IME payments for the prospective payment system for operating costs be returned to teaching hospitals that also receive DSH payments through a modification in the DSH adjustment for operating costs. We do not agree that the reduction in IME payments should be returned to teaching hospitals that also receive DSH payments. These hospitals currently have payment-to-cost ratios that are significantly higher than other hospitals. While we believe that it is possible to improve payment equity across all classes of hospitals by returning at least a portion of the IME payments to all hospitals, any such increase in payments to hospitals must be examined in the larger context of health care reform.

We strongly disagree that the low total operating margins (which are based on the facility's overall operations, not just Medicare patients) of DSH hospitals that also receive IME payments should be relevant to the distribution of Medicare payments. These lower total margins are associated with the fact that DSH hospitals that also receive IME payments tend to be faced with a broad array of social issues not directly related to Medicare patients, stemming largely from their location in urban areas and their role in providing services to low-income individuals. We continue to believe that social problems

that are not directly related to Medicare beneficiaries should be addressed through more targeted policies rather than through indirect subsidies in the form of higher payments to a class of hospitals that are not underpaid relative to the costs of treating Medicare beneficiaries.

C. Consistency of Indirect Medical Education and Disproportionate Share Adjustments to Prospective Payment System Capital and Operating Payments (Recommendation 5)

Recommendation: ProPAC recommends that the same level of IME and DSH payment adjustments be applied to both operating payments and the prospective component of capital payments, beginning in FY 1994. Further, ProPAC believes that the methods of determining these adjustments in the prospective payments for operating costs should also be applied to the prospective payments for capital-related costs as follows:

- The measure of teaching intensity used for the IME adjustments should be defined in terms of the ratio of residents per bed.
- The criteria for designation as a DSH should be based on urban or rural location and number of beds.

These changes would better reflect the policy objectives of the Congress in defining and setting the levels of the payment adjustments. They would also be consistent with the principle of incorporating capital into the prospective payment rate.

Response: We agree with ProPAC that an appropriate policy would be to apply the same DSH and IME adjustments to the prospective payments for operating costs and for capital-related costs. However, we continue to believe that the appropriate level of the adjustments is that justified by the total cost regressions, as developed in the August 30, 1991 final rule implementing the prospective payment system for capital-related costs (56 FR 43378). That is, the adjustments for both operating and capital payments should reflect the effect on total costs per case of IME and DSH status. We implemented these IME and DSH adjustments under the capital prospective payment system. We cannot implant them under the prospective payment system for operating costs since the IME and DSH operating adjustments are set by statute. Until we have statutory authority to change the IME and DSH adjustments to operating payments, we are faced with choosing between using different adjustments for capital and operating payments or making the IME and DSH adjustments to

capital payments at the same levels used for operating payments. Since our regression analysis indicates the adjustments to operating payments are not reflective of the effect that IME and DSH status have on Medicare costs per discharge, we believe it would be inappropriate to use these adjustments for capital payments. Thus, we have decided to use different adjustments and base the adjustments to capital payments on the results of the total cost regressions.

With regard to the ProPAC recommendation that the criteria for designation as a disproportionate share hospital should be based on urban or rural location and number of beds, we believe that the only hospital groups that should receive the DSH adjustment are those with significantly higher costs due to their disproportionate share of low income patients. As explained in further detail in the August 30, 1991 final rule implementing the prospective payment system for capital-related costs (56 FR 43378), we found no evidence in the total cost regressions that costs for any rural hospital grouping were significantly correlated with the DSH patient percentage. We also found no evidence that there is a correlation between the total costs per case of urban hospitals with fewer than 100 beds and their DSH patient percentage. For urban hospitals with at least 100 beds, we did not find a threshold disproportionate share patient percentage above which a higher adjustment formula was appropriate, nor did we find a threshold patient percentage below which no correlation exists between costs and patient percentage. For these reasons, we continue to believe that the DSH adjustment to capital payments, which provides an adjustment to only urban hospitals with more than 100 beds and does not require a threshold patient percentage, is correctly formulated and should apply to payments for operating costs as well.

We also disagree with the recommendation that the ratio of interns and residents to beds be used as the measure of teaching intensity for the IME adjustment to capital payments. As discussed in the August 30, 1991 final rule (56 FR 43380), we believe that the ratio of residents to average daily census is a more appropriate measure of teaching intensity. Residency programs are intended to provide participants the opportunity to treat patients in a supervised setting. We believe that the indirect costs of a teaching program are more highly correlated with the ratio of residents to the average number of patients than with the ratio of residents

to available beds, both occupied and unoccupied. This expectation is borne out by our regression results, which show both a smaller standard error and a slightly larger t-statistic when the resident-to-day ratio is used than when the resident-to-bed ratio is used in the cost regression.

In the August 30, 1991 final rule, we also stated our concern regarding the potential for manipulation of the bed count in order to increase teaching payments. In this regard, we note that the General Accounting Office, in its report on the IME adjustment for operating costs, refers to average daily census as a more "verifiable" statistic than beds. (A copy of this report, "Flawed Data Add Millions to Teaching Hospital Payments" GAO/IMTEC-91-31, June 1991, can be obtained by contacting the U.S. General Accounting Office, P.O. Box 6015, Gaithersburg, MD 20877, or by calling (202) 275-6421.)

D. Improvements in Labor Market Definitions (Recommendation 6)

Recommendation: ProPAC believes that the current prospective payment system labor market definitions need to be improved or replaced as soon as possible. Suitable alternative definitions, however, are not immediately available. In cooperation with the American Hospital Association (AHA) and HCFA, ProPAC is developing alternative labor market definitions that may alleviate many of the current problems. On the basis of this effort, ProPAC hopes to be able to recommend substantially revised labor market definitions for FY 1994.

Response: We agree with the Commission that the current labor market areas could be improved, and look forward to working with ProPAC and the AHA in examining potential improvements in the labor market definitions and the hospital wage index. At a minimum, we anticipate that the hospital wage index will be improved in FY 1994, due to the changes in the MSAs resulting from the 1990 census and the use of more recent wage data.

E. Medicare Transfer Payment Policy (Recommendation 7)

Recommendation: Cases transferred out of a hospital should be paid based on a graduated per diem up to the full DRG payment to recognize the higher daily costs associated with the first few days in a patient stay. In addition, outlier payment policy should be reexamined, particularly with respect to transfer cases received by a hospital. ProPAC believes that hospitals are penalized by the current payment for transfers and that further examination

of whether hospitals have the appropriate incentive to transfer patients, particularly with respect to recuperative care, is warranted.

Response: Since a Medicare discharge is the basis of payment under the prospective payment system, it is necessary to distinguish between discharges in which a patient has received complete treatment and discharges in which the patient is transferred to another acute-care hospital for related care. If a full DRG payment were made to each hospital involved in a transfer situation irrespective of the length of time the patient spent in the sending hospital prior to transfer, this would create a strong incentive to increase transfers, thereby unnecessarily endangering patients' health and increasing program outlays. Therefore, in a transfer situation, the regulations at § 412.4(d) provide that full payment is made to the final discharging hospital, and each transferring hospital is paid a per diem rate for each day of the stay, not to exceed the full DRG payment that would have been made if the patient had been discharged without being transferred. The per diem rate is determined by dividing the full DRG payment that would have been paid in a nontransfer situation by the average length of stay for the DRG into which the case falls. Transferring hospitals are also eligible for outlier payments for cases that meet the cost outlier criteria, but are not eligible for day outlier payments. Two exceptions to the transfer payment policy are transfer cases classified into DRG 385 (Neonates, Died or Transferred to Another Acute Care Facility) or DRG 456 (Burns, Transferred to Another Acute Care Facility), which are not paid on a per diem basis but receive the full DRG payment instead.

In the past, we have reviewed the transfer payment policy for potential improvements. The September 3, 1986 final rule (51 FR 31489) pointed out that, based on our analysis of the possible effects of making a single payment for all the hospitals involved in a transfer case, it was not possible to develop such a policy that would be equitable or administratively feasible. That is, we determined that a single payment based only on the DRG classification of one hospital would probably not be sufficient to be split equitably among the two or more hospitals based on the actual resources that each expended in the episode of care.

We issued a report to Congress in 1988 on the impact of outlier and transfer payment policies upon rural hospitals (Review of the Impact of

Outlier and Transfer Payment Policy upon Rural Hospitals, DHHS, 1988). We examined the ratio of payments under the prospective payment system to total charges in the transferring hospital by length-of-stay and found that the ratios were actually highest for the shortest lengths-of-stay and declined as length-of-stay increased. Furthermore, the ratios for cases with lengths-of-stay of up to 3 days exceeded those for all inpatient stays paid under the prospective payment system. Although the focus of that report was primarily on the impacts of outlier and transfer policy on rural hospitals, it concluded that the current policy was more practical than another potential alternative, establishing separate DRG categories for transfer cases.

ProPAC's report indicates that payment-to-cost ratios for transfer cases in the transferring hospitals were substantially below average for cases with short lengths-of-stay, but that the ratios were closer to average for cases with lengths-of-stay approximating the average. Since ProPAC's findings differ from those in our 1988 report to Congress, we intend to review ProPAC's results to determine whether refinements in the transfer payment policy are now warranted. (A ProPAC technical report containing the results of their analysis is scheduled for publication in April 1992.)

Any change in the transfer payment methodology needs to be evaluated in terms of its potential for creating incentives that may adversely affect the quality of care received by Medicare beneficiaries. For example, the declining per diem rate in a graduated per diem methodology would create an incentive for initiating transfers earlier in the course of treatment, potentially endangering patients' health. The magnitude of this incentive would depend on the gradation of the rate.

We share ProPAC's concern that the transfer payment policy not create substantial disincentives to the transfer of patients for recuperative care at a local hospital after completion of any specialty treatment provided in the tertiary hospital. However, we believe that, in light of the alternatives we have reviewed, our policy adequately maintains the efficiency incentives of the prospective payment system while establishing relatively neutral financial incentives to transfer or accept transfer patients. A decision to transfer a patient should be based upon the medical facts of a patient's case and not the financial effects upon the hospital.

F. Payment for Hemophilia Blood Clotting Factor (Recommendation 8)

Recommendation: ProPAC believes that current prospective payment system policies are adequate to prevent significant payment inequities for hospitals that treat Medicare beneficiaries with hemophilia. Therefore, ProPAC does not recommend reinstatement of an add-on payment for the costs of blood clotting factor provided to hemophilia patients. However, should the current situation change, ProPAC may reevaluate this issue.

Response: In 1989, ProPAC recommended implementation of a temporary, add-on payment for the costs of providing blood clotting factor to patients with hemophilia. ProPAC believed the add-on payment was necessary because of the rapidly increasing costs for clotting factor due in large part to manufacturing processes designed to reduce the risk of transmitting the human immunodeficiency virus. In response to ProPAC's recommendation, Congress enacted section 6011 of the Omnibus Budget Reconciliation Act of 1989 (Pub. L. 101-239), which amended section 1886(a)(4) of the Act to provide that hospitals paid under the prospective payment system receive an additional payment for the costs of administering blood clotting factor to hemophiliacs who are hospital inpatients. This add-on payment was effective for blood clotting factor furnished on or after June 19, 1990 and before December 19, 1991. A detailed discussion of this provision and its implementation can be found in the April 20, 1990 final rule with comment period (55 FR 15157) and the September 4, 1990 final rule (55 FR 36000).

ProPAC states that its analysis indicated that, in FY 1990, there were fewer than 3,000 Medicare discharges with hemophilia. Not all of them required blood clotting factor, and the vast majority of hospitals (94 percent) treated five or fewer cases. Therefore, ProPAC concluded that even though hemophiliacs are more costly to treat than the average case within a given DRG, there are insufficient data to indicate that these differences are due to the administration of clotting factor.

HCFA data analysis resulted in similar findings. Evaluation of hospital admissions in which blood clotting factor was administered (from June 19, 1990, when the add-on was implemented, to October 1, 1991) identified only 97 hemophilia inpatients. We found, as did ProPAC, that not only was there a low volume of patients, but also, there were very few hospitals with

a significant number of cases. Only eight hospitals administered clotting factor to four or more hemophilia patients. The impact of the increased cost of the clotting factor was distributed across 35 hospitals submitting claims for administering clotting factors to inpatients with hemophilia during the time period under analysis, with the majority of hospitals incurring only one admission.

As ProPAC states, the costs for the clotting factor are included in the hospital charges and are, therefore, reflected in the DRG weights. Under the prospective payment system, we do not pay for the costs of individual cases; rather, payment is based on an averaging process, as the cases in each DRG vary in resource requirements and length of stay. Given a normal distribution, most cases will require resources close to the average, with some cases costing more and some costing less. With the low volume of hemophilia inpatients requiring clotting factor, the higher costs for these cases are offset by the lower costs for other cases in the same DRG. In addition, the system does make provision for exceptionally high cost cases through outlier payments. Approximately 9 percent of the cases we analyzed received outlier payments.

We agree with ProPAC that, given the low volume of cases and the fact that these cases are not concentrated in a few hospitals, there is not sufficient justification to reinstate the add-on payment. Therefore, we support ProPAC's recommendation concerning the add-on payment for blood clotting factor provided to hemophilia patients.

G. Payment for Epilepsy Cases (Recommendation 9)

Recommendation: The current DRG assignment should be revised to account for the resource requirements of patients with epilepsy receiving intensive neurodiagnostic monitoring. ProPAC analyzed Medicare data from FY 1990 to identify patients with epilepsy in DRGs 24, 25, and 26 (Seizure and Headache) and found that payment-to-cost ratios were lower for patients with epilepsy compared to other patients in the same DRGs. These payment differences were greater for patients with intractable epilepsy and for those receiving neurodiagnostic monitoring. The Commission also found that the majority of patients with epilepsy were not concentrated in any hospital type but that hospitals providing specialized epilepsy services had a higher percentage of patients with epilepsy who receive monitoring. Therefore,

ProPAC believes that the Secretary should evaluate the current DRG assignment for patients with intractable epilepsy, particularly those receiving intensive neurodiagnostic monitoring.

Response: HCFA analyzed FY 1991 MEDPAR data and identified 22,223 discharges with a principal diagnosis of

epilepsy in DRGs 24, 25, and 26.

Although epilepsy represents 29 percent of all patients classified to these DRGs, intractable epilepsy accounts for only 3.7 percent (2,780 cases). Our findings parallel those of ProPAC, with epilepsy cases diagnosed as intractable having higher average charges (\$7310) than the

nonintractable cases (\$6274). These charges compare to \$6393 for all cases classified to DRG 24, 25, and 26. The following table summarizes the comparison of average charges between epilepsy and other cases assigned to the same DRGs. For each entry, the number of cases is included in the parentheses.

DRG	Intractable epilepsy	Nonintractable epilepsy	All epilepsy	All cases
24	\$8867 (1,606)	\$7260 (13,727)	\$7440 (15,333)	\$7400 (53,661)
25	\$5027 (1,173)	\$3901 (5,700)	\$4093 (6,873)	\$3977 (22,386)
26	\$4070 (1)	\$5959 (18)	\$5848 (17)	\$7174 (54)
All cases	\$7310 (2,780)	\$6274 (19,443)	\$6403 (22,223)	\$6393 (76,101)

If video and radio-telemetered electroencephalographic monitoring (procedure code 89.19) is performed, the result is higher charges, with both intractable and nonintractable patients receiving this service averaging a charge of \$7215, while those without the service had an average charge of \$6471. The differential in charges for intractable epilepsy cases with and without telemonitoring service, however, was less than 3 percent. With only 2 percent of the cases reporting codes for video-telemetering, and only two cases reporting psychological services, it is impossible to reach a definitive conclusion concerning the use and cost of neurodiagnostic services.

Evaluation of ancillary charges resulted in similar findings. That is, average ancillary charges were slightly above average for intractable patients and slightly below for nonintractable patients. Since 90 percent of the epilepsy admissions are for nonintractable cases and only 10 percent are for intractable, these slightly higher treatment costs for intractable cases are distributed across DRGs 24, 25, and 26, with some charges occurring above the average and some below. Given this distribution of cases, the average ancillary charge for all epilepsy patients (\$3,431) was actually lower than the average charge for all patients in these DRGs (\$3,541).

To measure the impact on hospitals of providing services to patients with intractable epilepsy, we evaluated utilization by these patients at the hospital level, identifying high-volume hospitals (defined as hospitals treating 10 or more intractable epilepsy cases). We found that for intractable epilepsy patients, there were 1,042 hospitals providing service to 2,780 patients, with fewer than 4 percent of these hospitals having 10 or more cases (40 hospitals).

Only 22 percent of the claims submitted by the high-volume hospitals for intractable epilepsy patients had charges that were higher than the average charge for the DRG for all patients. In addition, for approximately one-half of the claims submitted by these hospitals for all epilepsy patients in DRGs 24, 25, and 26, the average charge for treating intractable cases was less than the average charge for treating nonintractable cases.

Our evaluation of the relationship between Medicare costs and Medicare payments, for the first 7 years of prospective payment, identified only three high-volume hospitals with a negative average Medicare operating margin. (A negative operating margin means that a hospital incurred costs in excess of payment for its Medicare patients.) Without a high concentration of cases in a few hospitals, the impact of treating intractable epilepsy is distributed across many hospitals treating a low volume of these patients, with no significant impact on profit margins. This is consistent with the overall design of the prospective payment system. Under that system, payment is based on an averaging process, with some cases incurring costs in excess of payment while for others payment exceeds costs. The incentive is for hospitals to treat a mix of patients and, thus, achieve a balance between costs and payments.

As part of our analysis, we also examined the charge data from those 25 hospitals that were identified by the National Association of Epilepsy Centers as hospitals that specialize in the treatment of epilepsy. Based on our data, these epilepsy specialty centers did not necessarily treat a high volume of Medicare intractable epilepsy patients. The volume of these cases

ranged from 0 to 34. In addition, there was no consistent pattern concerning charges for either intractable or nonintractable epilepsy. The 10 specialty hospitals that were also high-volume hospitals (that is, treated 10 or more epilepsy cases) had average charges lower than the national average for these cases. We evaluated Medicare operating margins for the specialty centers, again reviewing the relationship between cost and payment for treating Medicare patients. As with the high-volume hospitals, the overall average operating margin for the first 7 years under prospective payment was positive. Only two centers (one of which was also a high-volume hospital) experienced an overall negative operating margin.

As ProPAC suggested, HCFA has evaluated the current DRG assignment for patients with intractable epilepsy, particularly those receiving intensive neurodiagnostic monitoring. While the results of our analysis confirm that intractable epilepsy patients incur higher charges on average than do patients with nonintractable epilepsy, particularly those receiving neurodiagnostic monitoring, these differences are not significant enough to warrant any DRG classification change.

We note that the data for both intractable and nonintractable cases were inconsistent across DRGs as well as among hospitals. Without accurate coding for the intensive services required for these patients, we cannot document consistent and reliable differences between patients receiving neurodiagnostic services and those not using these services. With minimal differences in average charges between intractable epilepsy cases and those of the DRG overall, given the distribution of cases across a large number of

hospitals and the inconsistencies between both the high-volume hospitals and the epilepsy treatment centers, we find there is insufficient evidence to justify a DRG modification at this time. Therefore, we are not proposing any revision to the current DRG assignment for epilepsy patients.

H. Essential Access Community Hospital Program (Recommendation 10)

Recommendation: ProPAC recommends that the Secretary waive, on an individual case basis, some of the requirements for participation in the Essential Access Community Hospital Program. This would encourage increased hospital participation and allow the Secretary to gain additional experience with alternative policies. Over time, policies should be expanded to target the larger group of hospitals that should continue to operate but offer limited, less specialized inpatient services. By refocusing these hospitals' operations, ProPAC believes that overall system efficiency may be improved without sacrificing access to care.

Response: On October 25, 1991, we published a proposed rule in the Federal Register to implement the Essential Access Community Hospital (EACH) program, including criteria that facilities would have to meet to qualify to be designated as EACHs or rural primary care hospitals (RPHs) (56 FR 55382). These criteria were based on the provisions of section 1820 of the Act (the statutory section that establishes the EACH program). That section of the Act does not include any mechanism for waiving the statutory requirements for designation as an EACH or RPH.

In response to our proposed rule, we received a number of comments recommending greater flexibility in the application of the statutory provisions cited by ProPAC, including the criteria for designation as an RPH. The provisions for which commenters recommended waiver included those provisions relating to the certification of the need for temporary inpatient care, the bed-size and length-of-stay limitations for RPHs, and the criteria related to the bed size or location of EACHs and their responsibilities with respect to RPHs. Some commenters expressed the opinion that HCFA should waive some or all of these provisions; other commenters recommended that we publish final regulations to permit the designation of "intermediate EACHs" that would appear to be similar in concept to the larger facilities that ProPAC believes should be encouraged to become more efficient through appropriate restructuring of their services.

We are considering these comments and will respond to them in the preamble to the final rule implementing the EACH program. We do not believe it would be appropriate to adopt any of the ProPAC recommendations outside of the rulemaking process.

I. PRO Review and Quality of Care (Unnumbered Recommendation)

Recommendation: ProPAC believes the Peer Review Organization (PRO) program should continue to monitor, at the case and facility levels, the care furnished to Medicare beneficiaries. Although the Commission commends the planned expansion of epidemiologic patterns of care studies using the Uniform Clinical Data Set, these more general analyses should not replace all case-level and facility-level quality review. Further, funding should be sufficient to allow PROs to perform case-level and facility-level review, as well as more general analyses of broad patterns of care.

Response: We intend to continue to monitor the care furnished to Medicare beneficiaries at the case and facility levels, as ProPAC recommends. HCFA has developed a new strategy for the PRO program, consistent with the recommendations in the 1990 Institute of Medicine Report, "Medicare: A New Strategy for Quality Assurance," to continuously improve quality of care, and to strengthen the ability of health care organizations and practitioners to assess and improve their own performance. This strategy is called the Health Care Quality Improvement Initiative (HCQII). Central to the HCQII is a fundamental change in the PRO program from its emphasis on individual (and often isolated) clinical errors to an increased emphasis on general improvements in medical care. Under the HCQII, PROs will use statistical quality control to examine variations in both the processes and the outcomes of care. PROs will then share these data with hospitals and physicians and work with them to interpret and apply the findings.

The HCQII is a program designed to shift the emphasis of Medicare quality assurance activity from review of individual cases to the review of patterns of care and patterns of outcomes. The Initiative is intended to move mainstream medical care toward best available practices, in contrast with a previous emphasis that focused on correcting unusually bad care.

The Initiative grows out of program experience, health services research, and modern quality management theory. Health services research indicates that there is wide variation in both practices

and outcomes for most conditions and procedures. Modern quality management shows that the emphasis on quality improvement should be on improving the usual processes of care rather than identifying an isolated problem with an individual case. The Initiative depends on collection of data through the Uniform Clinical Data Set, which will provide detailed clinical information.

PROs will continue to review individual cases under HCQII. About one-half of PRO resources will be expended on review of individual cases over the next 4 years. This review will continue to be carried out by local physicians working for the local PRO. Reviewing individual cases is an important complement to reviewing patterns of care and outcomes of care. Although there will be increased emphasis on pattern analysis and education, HCFA will continue to identify and act on individual quality problems. Hospitals that do not improve will be subject to increasingly severe actions, including sanctions. However, HCFA believes that education in concert with analysis of current patterns will produce greater improvements in care practices than do sanctions.

The Cooperative Cardiovascular Project is the first major clinical project of the HCQII. The Project will coordinate activities of PROs and the health care and research communities to improve care for patients with myocardial infarction, coronary artery bypass grafting, and percutaneous transluminal coronary angioplasty. The Project is being planned cooperatively by a group of interested organizations representing hospitals, consumers, researchers, and regulators. The Project will examine processes of care and outcomes of care for patients with these three conditions, identify areas in which practices can be improved, develop programs for improvement, and track the success of hospitals and medical staffs in achieving this improvement.

J. Update Factor for Payments to Dialysis Facilities (Recommendation 12)

Recommendation: ProPAC is not recommending an increase in payments for dialysis services at this time. Currently, data are inadequate to assess the relationship between the payments and the costs of furnishing various types of dialysis services in different settings. ProPAC recommends that HCFA expedite work necessary to complete its data base of unaudited dialysis facility cost reports. In addition, HCFA should annually audit the cost reports of a representative sample of dialysis

facilities and maintain a data base with this information.

Response: Section 4201(b) of the Omnibus Budget Reconciliation Act of 1990 (Pub. L. 101-508) directed ProPAC to conduct a study to determine the costs and services and profits associated with various modalities of dialysis treatments provided to end-stage renal disease (ESRD) patients under the Medicare program. Based on this information, ProPAC was directed to make recommendations to Congress regarding the method or methods of payment and the levels at which the payments made for the facility component of dialysis services by providers of service and renal dialysis facilities under Medicare should be established for dialysis services furnished during FY 1993 and the methodology to be used to update these payments for subsequent fiscal years. These recommendations were to be submitted as a report to Congress by March 1, before the beginning of each fiscal year, beginning with March 1, 1992 for FY 1993. The study was to examine the following factors: hemodialysis and other treatment modalities, adjustment factors for facility's characteristics, adjustments for labor and nonlabor costs, profit margin, and adjustments for patient complexity and costs associated with positive outcomes.

ProPAC believes that existing evidence, based on 1988 audit data, does not justify a rate increase at this time. The 1988 audit sample was designed to estimate the median costs of a dialysis service in an efficiently operated renal facility, that is, to set a rate for payment, and not to determine the costs of dialysis services that were affected by other factors (such as volume, type of ownership, and location of facility) as referenced by the statute. ProPAC concluded that the 1988 audit data were not representative of the proportion of patients treated at home, the types of dialysis provided, and the characteristics of all dialysis facilities. Thus, the Commission determined that this sample was not adequate to address the issues raised by Congress in Public Law 101-508 and that more extensive cost data was needed.

We agree with ProPAC's assessment that the 1988 audit data were not

sufficient to address the issues raised by Congress, as the audits were not designed to provide data on the issues raised in the Congressional mandate. We have been developing data and have recently completed a data base of unaudited renal cost data. We are maintaining computer files of cost report data for renal facilities with fiscal years ending in 1988, 1989, 1990 and 1991, and have initiated an analysis of these data. ProPAC is aware that we now have data in the format required and has requested access to these data.

ProPAC is also recommending that we annually audit a representative sample of cost reports to use in evaluating payments and costs by type of treatment and setting. This is an appropriate recommendation for rate-setting purposes, but we do not believe it would be cost effective to conduct annual audits under the prospective payment system, since there is no recovery of Medicare funds to offset the costs of these audits, nor does the Secretary have the authority under Public Law 101-508 to set rates. Moreover, we believe that a representative set of audits could be useful to the Secretary to set annual payment rates, if the Secretary had the authority to set rates. We believe that to conduct audits without the authority to use these results to set rates would result in inefficient use of government expenditures.

Presented below are tables that provide data from 1990 ESRD facility surveys, including both hospital-based and independent facilities, and a table that shows the percentage of patients by treatment modalities. Tables 1, 2 and 3 provide information concerning the universe of renal facilities. Over the past 10 years, the number of independent facilities has increased significantly. These facilities account for the majority of dialysis treatments. The 1990 data show that independent facilities account for 66 percent of all renal facilities and furnish dialysis service to 66 percent of all dialysis patients.

Table 3 shows that for 1990, 39 percent of renal facilities furnish 68 percent of outpatient maintenance dialysis treatments. This is in contrast to the situation in 1983, when the original base rates were established. At that

time, the rates were weighted using the costs experiences of small renal units, especially hospitals, which then dominated the dialysis industry. This resulted in overpaying the more efficient larger facilities. We believe that ProPAC should consider a payment method that establishes different rates for the larger, more efficient renal facilities that benefit from economies of scale. For facilities that meet certain limited criteria, we are considering a different payment structure based on the characteristics of these facilities. For example, pediatric hospitals and small rural facilities, with less than a defined number of treatments, might qualify for an adjusted rate that reflects the relative inefficiencies associated with low volume. For hospitals, a case-mix adjustment would be appropriate to eliminate the administrative burden and costs borne by hospitals filing for an exception to their payment rates.

Table 4 documents that in 1990 the treatment modalities for 97 percent of renal patients were outpatient hemodialysis, CAPD (continuous ambulatory peritoneal dialysis) or CCPD (continuous cycling peritoneal dialysis). This percentage continues to grow and the rate structure should reflect this shift in treatment modalities. The numbers of intermittent peritoneal dialysis (IPD) and home hemodialysis patients are insignificant and diminishing, and no special payment structure should be established for these treatment modalities. Patients on IPD should be reflected in any case-mix adjustment proposed by ProPAC. Since 1982, the percentage of patients on home hemodialysis has decreased from 6.7 percent to 1.9 percent. Of these home patients, 2 percent of renal facilities account for 43 percent of all patients. In total, 21 percent of renal facilities account for 78 percent of all home dialysis patients. If ProPAC recommends setting a separate home dialysis rate, we would suggest that only those facilities that have a significant home patient population be used to establish the payment rate in order to reflect the economic efficiencies and training expertise of such programs.

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TABLE 1: HOSPITAL DATA FROM 1990 ESRD FACILITY SURVEY

RANGE OF HOSPITAL FACILITIES' TREATMENTS

RANGE	UNITS	HEMO RXS	HEMO PATs	TOTAL PATs	AVG RXs
NO TREATMENTS	18	0	0	38	0
1 - 2,499	168	210548	1830	2643	1253
2,500 - 4,999	157	579238	4222	5795	3689
5,000 - 7,499	114	711744	5057	6958	6243
7,500 - 9,999	96	837722	6035	7922	8726
10,000 - 14,999	77	934659	6884	9004	12138
15,000 - 19,999	39	671950	4721	6214	17229
20,000 OVER	20	541086	3807	5000	27054
TOTAL	689	4486947	32556	43574	6512

RANGE OF RURAL HOSPITAL FACILITIES TREATMENTS

RANGE	UNITS	HEMO RXS	HEMO PATs	TOTAL PATs	AVG RXs
NO TREATMENTS	1	0	0	0	0
1 - 2,499	55	80717	628	657	1468
2,500 - 4,999	67	236009	1708	2134	3523
5,000 - 7,499	20	121127	874	1032	6056
7,500 - 9,999	6	49533	369	409	8256
10,000 - 14,999	2	21475	162	215	10738
15,000 - 19,999	0	0	0	0	0
20,000 OVER	0	0	0	0	0
TOTAL	151	508861	3741	4447	3370

RANGE OF URBAN HOSPITAL FACILITIES' TREATMENTS

RANGE	UNITS	HEMO RXS	HEMO PATs	TOTAL PATs	AVG RXs
NO TREATMENTS	17	0	0	38	0
1 - 2,499	113	129831	1202	1986	1149
2,500 - 4,999	90	343229	2514	3661	3814
5,000 - 7,499	94	590617	4183	5926	6283
7,500 - 9,999	90	788189	5666	7513	8758
10,000 - 14,999	75	913184	6722	8789	12176
15,000 - 19,999	39	671950	4721	6214	17229
20,000 OVER	20	541086	3807	5000	27054
TOTAL	538	3978086	28815	39127	7394

TABLE 2: INDEPENDENT DATA FROM 1990 ESRD FACILITY SURVEY

RANGE OF INDEPENDENT FACILITIES' TREATMENTS

RANGE	UNITS	HEMO	HEMO	TOTAL	AVG
		RXS	PATs	PATs	RXs
NO TREATMENTS	18	0	0	509	0
1 - 2,499	229	287459	4541	4950	1255
2,500 - 4,999	271	1014465	7990	8885	3743
5,000 - 7,499	242	1480978	10828	12563	6120
7,500 - 9,999	189	1636675	11935	13691	8660
10,000 - 14,999	223	2723589	19342	22803	12213
15,000 - 19,999	80	1372358	9670	11024	17154
20,000 OVER	55	1502806	9844	11801	27324
TOTAL	1307	10018330	74150	86226	7665

RANGE OF RURAL INDEPENDENT FACILITIES' TREATMENTS

RANGE	UNITS	HEMO	HEMO	TOTAL	AVG
		RXS	PATs	PATs	RXs
NO TREATMENTS	2	0	0	90	0
1 - 2,499	96	127496	1438	1515	1328
2,500 - 4,999	101	371603	2730	3061	3679
5,000 - 7,499	64	382890	2755	2927	5983
7,500 - 9,999	30	258095	1790	1950	8603
10,000 - 14,999	14	165124	1139	1247	11795
15,000 - 19,999	2	33119	216	287	16560
20,000 OVER	1	20388	151	217	20388
TOTAL	310	1358715	10219	11294	4383

RANGE OF URBAN INDEPENDENT FACILITIES' TREATMENTS

RANGE	UNITS	HEMO	HEMO	TOTAL	AVG
		RXS	PATs	PATs	RXs
NO TREATMENTS	16	0	0	419	0
1 - 2,499	133	159963	3103	3435	1203
2,500 - 4,999	170	642862	5260	5824	3782
5,000 - 7,499	178	1098088	8073	9636	6169
7,500 - 9,999	159	1378580	10145	11741	8670
10,000 - 14,999	209	2558465	18203	21556	12241
15,000 - 19,999	78	1339239	9454	10737	17170
20,000 OVER	54	1482418	9693	11584	27452
TOTAL	997	8659615	63931	74932	8686

TABLE 3: INDEPENDENT & HOSPITAL DATA FROM 1990 ESRD FACILITY SURVEY

RANGE OF HOSPITAL & INDEPENDENT FACILITIES' TREATMENTS

RANGE	UNITS	HEMO RXS	HEMO PATs	TOTAL PATs	AVG RXs	% OF UNITS	CUMUL %	% OF RXS	CUMUL %
NO TREATMENTS	36	0	0	547	0	1.8%	1.8%	0.0%	0.0%
1 - 2,499	397	496007	6371	7593	1254	19.9%	21.7%	6.0%	6.0%
2,500 - 4,999	428	1593703	12212	14680	3724	21.4%	43.1%	11.4%	17.4%
5,000 - 7,499	356	2192722	15885	19521	6159	17.8%	61.0%	14.9%	32.3%
7,500 - 9,999	285	2474397	17970	21613	8682	14.3%	75.3%	16.8%	49.1%
10,000 - 14,999	300	3658248	26226	31807	12194	15.0%	90.3%	24.6%	73.7%
15,000 - 19,999	119	2044308	14391	17238	17179	6.0%	96.2%	13.5%	87.2%
20,000 OVER	75	2043892	13651	16801	27252	3.8%	100.0%	12.8%	100.0%
TOTAL	1996	14505277	106706	129800	7267	100%		100%	

RANGE OF RURAL HOSPITAL & INDEPENDENT FACILITIES' TREATMENTS

RANGE	UNITS	HEMO RXS	HEMO PATs	TOTAL PATs	AVG RXs	% OF UNITS	CUMUL %	% OF RXS	CUMUL %
NO TREATMENTS	3	0	0	90	0	0.7%	0.7%	0.0%	0.0%
1 - 2,499	151	208213	2066	2172	1379	32.8%	33.4%	14.8%	14.8%
2,500 - 4,999	168	607612	4438	5195	3617	36.4%	69.8%	31.8%	46.6%
5,000 - 7,499	84	504017	3629	3959	6000	18.2%	88.1%	26.0%	72.6%
7,500 - 9,999	36	307628	2159	2359	8545	7.8%	95.9%	15.5%	88.1%
10,000 - 14,999	16	186599	1301	1462	11662	3.5%	99.3%	9.3%	97.4%
15,000 - 19,999	2	33119	216	287	16560	0.4%	99.8%	1.5%	98.9%
20,000 OVER	1	20388	151	217	20388	0.2%	100.0%	1.1%	100.0%
TOTAL	461	1867576	13960	15741	4051	100%		100%	

RANGE OF URBAN HOSPITAL & INDEPENDENT FACILITIES' TREATMENTS

RANGE	UNITS	HEMO RXS	HEMO PATs	TOTAL PATs	AVG RXs	% OF UNITS	CUMUL %	% OF RXS	CUMUL %
NO TREATMENTS	33	0	0	457	0	2.1%	2.1%	0.0%	0.0%
1 - 2,499	246	289794	4305	5421	1178	16.0%	18.2%	4.6%	4.6%
2,500 - 4,999	260	986091	7774	9485	3793	16.9%	35.1%	8.4%	13.0%
5,000 - 7,499	272	1688705	12256	15562	6208	17.7%	52.8%	13.2%	26.2%
7,500 - 9,999	249	2166769	15811	19254	8702	16.2%	69.1%	17.0%	43.3%
10,000 - 14,999	284	3471649	24925	30345	12224	18.5%	87.6%	26.9%	70.2%
15,000 - 19,999	117	2011189	14175	16951	17190	7.6%	95.2%	15.3%	85.4%
20,000 OVER	74	2023504	13500	16584	27345	4.8%	100.0%	14.6%	100.0%
TOTAL	1535	12637701	92746	114059	8233	100%		100%	

TABLE 4: PERCENTAGE OF PATIENTS BY TREATMENT MODALITIES

YEAR	HEMO	IPD	ALL	HEMO	IPD	CAPD	CCPD	TOTAL
	OUTPAT	OUTPAT	TRAIN MODES	HOME	HOME	HOME	HOME	
1982	79.92%	1.35%	0.89%	6.68%	1.24%	9.92%	0.00%	100.0%
1983	79.22%	1.03%	0.79%	6.01%	1.10%	11.85%	0.00%	100.0%
1984	79.22%	0.75%	0.61%	5.26%	0.33%	12.74%	1.09%	100.0%
1985	79.30%	0.69%	0.67%	4.70%	0.27%	13.25%	1.12%	100.0%
1986	80.05%	0.56%	0.59%	4.04%	0.21%	13.11%	1.44%	100.0%
1987	80.62%	0.45%	0.36%	3.64%	0.17%	13.03%	1.74%	100.0%
1988	81.40%	0.34%	0.55%	3.02%	0.31%	12.57%	1.81%	100.0%
1989	81.96%	0.27%	0.36%	2.51%	0.14%	12.77%	1.99%	100.0%
1990	81.99%	0.22%	0.35%	1.91%	0.15%	13.07%	2.31%	100.0%
TOTAL	80.62%	0.56%	0.54%	3.88%	0.37%	12.60%	1.43%	100.0%

BILLING CODE 4120-01-C

K. Outpatient Payment Reform (Recommendation 13)

Recommendation: ProPAC believes that a prospective payment system for outpatient services should be implemented. Outpatient facility payment reform should ultimately include all providers of outpatient services, such as hospitals, physicians' offices, and free-standing ambulatory surgical centers. The same payment method should apply to the facility or technical component of all services. The payment rate, however, should be adjusted to reflect justifiable cost differences such as wages and case mix. Further, cost differences that have some societal benefit, such as standby capacity and emergency capabilities, should also be reflected in the payment rate. Where feasible, the unit of payment should be based on bundled related services.

Response: This recommendation raises a number of important issues. We are committed to the development of a prospective payment system for hospital outpatient departments. We believe the system we design should result in certain benefits, such as increasing payment equity among providers, constraining Medicare expenditures, and protecting beneficiaries' access to services, while promoting predictability and administrative simplicity. In addition, we agree with ProPAC that ideally the same prospective payment system should eventually be extended to the other outpatient settings.

In its discussion of this recommendation, ProPAC raises the concern that our current research focuses only on hospital-provided outpatient services, and they encourage the expansion of research to other outpatient facilities as well. For example, ProPAC notes that the Ambulatory Patient Groups (APGs) classification system was developed for use in the hospital outpatient setting, and questions whether APGs can be appropriately applied in the nonhospital setting.

It is true that we have initially focused on the development of the Congressionally mandated prospective payment system for hospital outpatient services. However, we see this as a first and necessary step to a comprehensive system that could be applied to nonhospital settings as well. In addition, we do not believe that there is any feature inherent in a clinically-based case-mix classification system such as APGs that would preclude it from being used as the payment method for other outpatient settings.

L. Medicare Volume Performance Standard (Recommendation 14)

Recommendation: Services provided in the hospital outpatient setting should be included in the Medicare Volume Performance Standard (MVPS) to the extent that these services are included when provided in other settings. Certain services, such as laboratory tests and therapy, currently are included in the MVPS when they are furnished in free-standing settings. ProPAC believes that hospital-provided outpatient services should also be incorporated in the VPS. Their inclusion will make incentives to control volume consistent across sites of care.

Response: In theory, we agree that services provided in the outpatient department of hospitals should be included in the MVPS because physicians should be held accountable for the services they order as well as provide. However, until a process is established for obtaining more timely data from the intermediaries than currently exists through the cost report process, only clinical diagnostic laboratory tests provided in the outpatient department can feasibly be brought into the MVPS.

With respect to other hospital outpatient department services, the data needed to include these services in the MVPS are not available on a timely basis as long as payment continues on a reasonable cost basis. While charge data from the hospital outpatient department can be obtained in a timely manner, we would not be able to obtain accurate expenditure information for the purpose of measuring performance under the MVPS for the year ending September 30 because of varying fiscal year ending dates for cost reports and delays in settlement of the cost report. Thus, we do not think it is feasible to include in the MVPS any hospital outpatient services that are paid for on a reasonable cost basis.

M. Cost Data Collection for Outpatient Providers (Recommendation 15)

Recommendation: A mechanism should be implemented for periodic collection of procedure-specific cost data in free-standing settings, including physicians' offices and ambulatory surgical centers.

Response: We have specifically chosen not to require Medicare-participating ambulatory surgical centers (ASCs) to submit annual cost reports, primarily to avoid imposing on ASCs the burden and expense that these reports engender. Some ASCs, especially the smaller facilities, would have difficulty absorbing the added

expense of maintaining billing and recordkeeping systems necessary to satisfy an annual Medicare cost report requirement. Additional facility costs would, in turn, be reported to Medicare, inflating Medicare ASC payment rates and beneficiary co-payments (see Recommendation 16 below) as well as Medicare administrative costs. Therefore, we do not concur with the ProPAC recommendation that an annual cost report would be an appropriate mechanism for the systematic and comprehensive collection of data for free-standing settings.

We surveyed Medicare-participating ASCs in 1986 to collect procedure-specific cost data for use in setting ASC payment rates. Also, an ASC survey will be conducted during 1992. These surveys collect information regarding charges, costs, and volume on a procedure-specific basis. One portion of the 1992 survey will ask ASCs to identify component services of selected high-volume procedures and to report their actual costs in furnishing those services. The data reported for this "procedure costing" portion of the 1992 survey as well as the more general charge, cost, and utilization data collected from all ASCs are validated by random on-site audits of a representative sample of facilities. We have found this method of data collection to be cost effective at both the national and provider level and minimally disruptive to the industry. The increase in the number of Medicare-certified ASCs from slightly fewer than 500 in 1986 to more than 1400 in 1992 suggests that our current data collection procedures are not a significant impediment to Medicare participation by ASCs.

HCFA is currently sponsoring research to obtain facility cost data (that is, excluding physician professional service costs) on a sample of about 400 frequently found procedures in hospital outpatient departments, ambulatory surgical centers, and physicians' offices. The research, due to HCFA in 1993, will demonstrate a methodology for collecting and analyzing these data and enable us to explore the reasons for differences in costs between types of outpatient sites. After the report is delivered, HCFA will be able to determine whether or not the data collection should be performed periodically.

N. Beneficiary Liability (Recommendation 16)

Recommendation: Beneficiary Part B coinsurance for hospital outpatient services that are paid for prospectively

should be limited to 20 percent of the payment amount allowed by Medicare.

Response: We recognize ProPAC's concern. We have been reviewing this issue in the context of our development of a comprehensive prospective payment system for all hospital outpatient services. We are working to develop an approach that will be fair to beneficiaries, while minimizing the negative financial impact on the Medicare program.

O. Quality of Care in Outpatient Settings (Recommendation 17)

Recommendation: ProPAC is concerned about the lack of Federal quality oversight in many ambulatory care settings. As more services are furnished in outpatient settings, ProPAC believes the Secretary should enhance existing methods and develop new ones to assess and monitor the quality of care provided to beneficiaries in these settings.

Response: We agree with ProPAC's recommendation regarding the need for better assessment and monitoring of the quality of care provided to beneficiaries in ambulatory care settings. We have two projects underway that we expect will give us the necessary information to review patient care provided in physician offices and other ambulatory settings. In both cases, PROs have joined with academic medical experts to develop this information, and in both cases the approach is educational rather than regulatory.

In response to a Request for Proposal issued in 1989, the Wisconsin Peer Review Organization was awarded a contract to review care in physician offices. Data are being abstracted for records from 10 medical conditions commonly found in the Medicare population. Evaluation of risk-adjusted outcomes for these conditions will provide clues as to which patterns of interventions are likely to affect patient outcomes significantly.

The second project was awarded in 1990 to the Delmarva Foundation for Medical Care (the PRO for Maryland). Under this 3-year project, primary care physicians will be compared to their peers on the adequacy of record documentation and the performance of routine clinical functions such as testing, prescribing and monitoring drugs, procedures and diagnoses.

Both of these projects will emphasize providing physicians with data regarding their performance. We believe that the results obtained from these two projects will help us to implement an effective system of ambulatory care review.

In addition, section 4205(c) of Pub. L. 101-508 sets forth a number of requirements to enhance PRO/carrier coordination. In February 1991, all PROs were directed to exchange with carriers all medical policies and review guidelines, including screens and criteria, for new technologies and invasive procedures. In August 1991, five PROs and carriers (Connecticut, Maryland, North Carolina, Texas, and Wisconsin) began a pilot project for further exchange of information, including lists of physicians, to examine any commonality in their medical review activities. This pilot project should also prove beneficial in examining physicians who treat patients primarily on an outpatient basis.

Furthermore, HCFA has created a Fourth Scope of Work Workgroup to examine and develop a revised scope of work for the PROs as we begin implementing the HCQII to focus on evaluating quality of care in terms of the outcomes of care. (See the detailed discussion of HCQII above, in section VIII.I of this preamble.) We will continue to pursue pilot projects among the PROs to field test methods of performing review in ambulatory care settings. The results of these field tests will be used to design and implement a national program of review of ambulatory care.

P. Payment for Hospital-Provided Outpatient ASC-Approved Surgery (Recommendation 18)

Recommendation: ProPAC believes that payments for ambulatory surgery performed in the hospital outpatient setting should be fully prospective based on national rates adjusted for area wage differences. The payment rates should be established using average hospital costs and freestanding ASC payments. These rates should be computed in a budget neutral fashion, that is, aggregate spending should neither increase or decrease. National rates should be based on the classification system used to determine payments to free-standing ASCs. However, ProPAC believes this classification system should be revised, as noted in Recommendation 19. The rates should be updated annually using an appropriate update factor.

Response: We agree with ProPAC that payment for ambulatory surgery performed in the hospital outpatient setting should be fully prospective. As noted in Recommendation 13 above, we are in the process of developing a comprehensive prospective payment system for all hospital outpatient services. However, additional research and evaluation are needed before such a comprehensive prospective payment

system can be implemented. Therefore, we anticipate that we will first propose a limited transitional prospective payment system for hospital outpatient services. We are currently evaluating a number of approaches for implementing this transitional system, among them proposals that, as ProPAC recommends, would use ASC data to help establish payment rates for hospital outpatient surgical services.

Q. Revision of the Classification System Used to Group Ambulatory Surgery Cases (Recommendation 19)

Recommendation: The Secretary should revise the classification system used to group ambulatory surgery cases for payment. Cases treated in both hospitals and freestanding ambulatory surgical centers (ASCs) should be used to establish the payment groups.

Response: In compliance with section 1833(i)(2)(A) of the Act, the current ASC payment classification system groups Medicare covered Physicians' Current Procedural Terminology (CPT) codes so as to assure that the standard overhead payment amount established for the procedures in each group takes into account the costs incurred by ASCs generally in providing services furnished in connection with the performance of those procedures.

Absent a complete revision of those sections of the Act that provide for the ASC benefit under Medicare, Part B, combining hospital data with freestanding ASC data to establish a classification system for payments to ASCs would not be in compliance with the law.

R. Payment for Hospital-Provided Outpatient Radiology Services (Recommendation 20)

Recommendation: ProPAC believes that payments for radiology services provided in the hospital outpatient setting should be fully prospective based on national rates adjusted for area wage differences. The payment rates should be established using average hospital costs and the technical component of the Medicare fee schedule for physicians. These rates should be computed in a budget neutral fashion; that is, aggregate spending should neither increase nor decrease. The national rates should be updated annually using an appropriate update factor.

Response: We agree with ProPAC that payment for radiology services performed in the hospital outpatient setting should be fully prospective. Again, we are in the process of developing a comprehensive prospective

payment system for all hospital outpatient services. As noted above, we anticipate that we will first propose a transitional system and we are in the process of evaluating a number of approaches for implementing such a system. For radiology services, we will evaluate, among other approaches, using the blend recommended by ProPAC.

S. Payment Adjustments for Hospital-Provided, ASC-Approved Surgery and Radiology Services (Recommendation 21)

Recommendation: ProPAC believes that national prospective payment rates for ASC-approved ambulatory surgery and radiology services should be adjusted to reflect differences in labor costs. This adjustment should take into account the appropriate labor share and occupational mix of ASC-approved surgery and radiology services in the hospital outpatient setting. The Secretary should conduct additional research to determine whether other adjustments are warranted.

Response: We currently do not have access to the necessary data to implement this recommendation. For example, hospitals would have to maintain records that would provide a breakdown of salaries and personnel hours attributable to inpatient and outpatient services. We are concerned that any future requirement for collecting the necessary data might place an undue administrative burden on hospitals. However, we encourage comments from hospitals with respect to how burdensome it would be to maintain such detail.

We would welcome comments from hospitals on this recommendation, particularly with regard to the scope and effects of the additional collection that would be required to carry out this recommendation.

T. Nursing Facility Wage Index (Recommendation 22)

Recommendation: The Secretary should collect data on employee compensation and paid hours of employment for nursing facilities that care for Medicare SNF patients. Once these data become available, the Secretary should develop a nursing facility wage index and use it to adjust Medicare SNF payments.

Response: ProPAC simulated a nursing facility wage index with limited data and found significant differences from the hospital wage index. However, ProPAC indicates that these differences could be due to differences in State regulations that affect nursing homes. The differences in State regulations should be minimized drastically with the

implementation of the nursing home reform provisions of the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100-203), effective October 1, 1990, which made the certification requirements for SNFs virtually identical for both Medicare and Medicaid.

ProPAC states that another potential reason for the failure of the hospital wage index to reflect adequately the variation in SNF wages is the skill-mix differences between hospital and nursing facility personnel. We agree that there may be a skill-mix difference between hospitals and skilled nursing facilities. We do not know whether the differences in the skill mix would result in a different wage index.

ProPAC also notes that the current system contributes to inequitable Medicare SNF payments across regions. For example, almost half of the facilities in New England and almost a third of those in the Mid-Atlantic region receive less than 85 percent of their costs. This compares with an average of only 15 percent of the facilities in other regions. We believe, however, that factors other than the current wage index are responsible for the higher than average costs being reported for the facilities in New England and the Mid-Atlantic States. Among these factors are the nursing shortage and the fact that some of those States pay for SNF services under Medicaid using a prospective case-mix system, which encourages facilities to admit higher cost, resource-intensive patients.

Furthermore, based on our experience with similar attempts to mandate the establishment of a home health agency (HHA) based wage index for determining HHA cost limits, we believe it advisable to continue using the hospital wage index for SNFs until the SNF payment system is totally revised through legislation.

U. Nursing Facility Case-Mix Adjustment (Recommendation 23)

Recommendation: ProPAC believes that the payment system should recognize differences in the costs of care for different types of patients. Therefore, it supports the Secretary's efforts to develop and implement a case-mix adjustment to Medicare SNF payments under the Multistate Nursing Home Case Mix and Quality Demonstration. If the case-mix adjustment developed under the demonstration proves to be appropriate, it should be implemented.

Response: As ProPAC indicates, the Secretary will conduct a demonstration to implement a case-mix adjustment to Medicare SNF payments. The

demonstration is scheduled to begin in July 1993, and we will consider its findings.

IX. Other Required Information

A. Paperwork Reduction Act

Sections 412.230 and 412.273 contain information collection requirements that are subject to Office of Management and Budget (OMB) review under the Paperwork Reduction Act. Section 412.230 has been approved by OMB through October 1993 under OMB control number 0938-0573. Section 412.273 contains a new requirement whereby a hospital may request the Administrator to review a denial. Burden associated with this collection of information is estimated to be 1 hour per respondent. A notice will be published in the *Federal Register* when approval is obtained. Organizations and individuals desiring to submit comments regarding the burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, may submit them to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, DC 20503.

B. Requests for Data from the Public

In order to respond promptly to public requests for data related to the prospective payment system, we have set up a process under which commenters can gain access to the raw data on an expedited basis. Generally, the data are available in computer tape format; however, some files are available on diskette. Data sets are listed below with the cost of each. Anyone wishing to purchase data tapes should submit a written request along with a certified check or money order (payable to HCFA) to cover the cost of the tapes or diskettes to the following address: HCFA Office of Statistics and Data Management, Bureau of Data Management and Strategy, Room 3-A-12 Security Office Park Building, 6325 Security Boulevard, Baltimore, MD 21207.

1. Expanded Modified MEDPAR File

The file contains records for 100 percent of Medicare beneficiaries using hospital inpatient services. The file is stripped of most data elements that would identify beneficiaries. The hospitals are identified. The file is available to persons qualifying under the terms of the Notice of Proposed New Routine Use for an Existing System of Records published in the *Federal Register* on December 24, 1984 (49 FR 49941), which was amended by the July

2. 1985 Notice of Proposed New Routine Use for an Existing System of Records (50 FR 27361). Under the requirements of these notices, a data release agreement must be signed by the purchaser before release of these data.

Expanded Modified MEDPAR—Hospital Inpatient Periods Available: FY 1988 through FY 1991

Price: \$3,150.00 per fiscal year

2. HCFA Hospital Wage Index Survey

This tape contains three files. Included are the hospital hours and salaries for 1988 used to create the wage indexes used in the Medicare Hospital Prospective Payment System (PPS) as well as all wage indexes used since October 1, 1983. It also contains a list of State and county codes used by SSA and FIPS (Federal Information Processing Standards), county name, and Metropolitan Statistical Area (MSA), since October 1, 1983.

Periods Available: FY 1993 PPS Update
File Cost: \$460.00

3. H180 Extract, Cost Reporting Periods Ending January 1, 1982 through September 29, 1983

The H180 Extract contains cost, statistical, financial, and other information from the Medicare Hospital Cost Report (HCFA Form 2552-81). The data set includes as submitted, final settled and reopened cost reports as they were received from the Medicare Fiscal Intermediary. There is a single record for each Medicare Cost Report submitted for a Medicare Certified Hospital by the Medicare Fiscal Intermediary. This file is no longer updated.

Price: \$660.00

4. TEFRA Minimum Data Set, Cost Reporting Periods Beginning On or After October 1, 1982 and Before October 1, 1983.

The TEFRA Minimum Data Set contains cost, statistical, financial, and other information from the Medicare Hospital Cost Report (HCFA Form 2552-83) for the Hospital Fiscal Periods beginning on or after October 1, 1982 and before October 1, 1983. This dataset includes capital-related cost (fixed/moveable) information used in the early analyses of prospective capital payment. The majority of these cost reports have been settled by the Medicare Fiscal Intermediary. This file is no longer updated.

Price: \$660.00

5. PPS-I Minimum Data Set, Cost Reporting Periods Beginning On or After October 1, 1983 and Before October 1, 1984

The PPS-I Minimum Data Set contains cost, statistical, financial, and other information from the Medicare hospital cost report (HCFA Form 2552-84). The dataset includes only the most current cost report (as submitted, final settled or reopened) submitted for a Medicare Certified Hospital by the Medicare Fiscal Intermediary to HCFA. The majority of these cost reports have been settled by the Medicare Fiscal Intermediary. This file is no longer updated.

Price: \$660.00

6. PPS-II Minimum Data Set, Cost Reporting Periods Beginning On or After October 1, 1984 and before October 1, 1985

The PPS-II Minimum Data Set contains cost, statistical, financial, and other information from the Medicare hospital cost report (HCFA Form 2552-85). The dataset includes only the most current cost report (as submitted, final settled or reopened) submitted for a Medicare Certified Hospital by the Medicare Fiscal Intermediary to HCFA. This dataset is updated by the end of each calendar quarter and is available on the last day of the following month.

Price: \$660.00

7. PPS-III Minimum Data Set, Cost Reporting Periods beginning on or after October 1, 1985 and before October 1, 1986

The PPS-III Minimum Data Set contains cost, statistical, financial, and other information from the Medicare hospital cost report (HCFA Form 2552-85). The dataset includes only the most current cost report (as submitted, final settled or reopened) submitted for a Medicare Certified Hospital by the Medicare Fiscal Intermediary to HCFA. This dataset is updated by the end of each calendar quarter and is available on the last day of the following month.

Price: \$660.00

8. PPS-IV Minimum Data Set, Cost Reporting Periods Beginning On or After October 1, 1986 and Before October 1, 1987

The PPS-IV Minimum Data Set, contains cost, statistical, financial, and other information from the Medicare hospital cost report (HCFA Form 2552-85). The dataset includes only the most current cost report (as submitted, final settled or reopened) submitted for a Medicare Fiscal Intermediary to HCFA. This dataset is updated by the end of

each calendar quarter and is available on the last day of the following month.
Price: \$660.00

9. PPS-V Minimum Data Set, Cost Reporting Periods Beginning On or After October 1, 1987 and Before October 1, 1988

The PPS-V Minimum Data Set, contains cost, statistical, financial, and other information from the Medicare hospital cost report (HCFA Form 2552-85). The dataset includes only the most current cost report (as submitted, final settled or reopened) submitted for a Medicare Fiscal Intermediary to HCFA. This dataset is updated by the end of each calendar quarter and is available on the last day of the following month.

Price: \$660.00

10. PPS-VI Minimum Data Set

The PPS-VI Minimum Data Set contains cost, statistical, financial, and other information from the Medicare Hospital Cost Report (Form HCFA 2552-85) for the Hospital Fiscal Periods beginning on or after October 1, 1988 and before January 1, 1989 and (Form HCFA 2552-89) for the Hospital Fiscal Periods beginning on or after January 1, 1989 and before October 1, 1989. The dataset includes only the most current cost report (as submitted, final settled or reopened) submitted for a Medicare Certified Hospital by the Medicare Fiscal Intermediary to HCFA. This dataset is updated by the end of each calendar quarter and is available on the last day of the following month.

Price: \$660.00

11. PPS-VII Minimum Data Set

The PPS-VII Minimum Data Set contains cost, statistical, financial and other information from the Medicare Hospital Cost Report (Form HCFA 2552-85) for the Hospital Fiscal Periods beginning on or after October 1, 1989 and before January 1, 1990 and (Form HCFA 2552-89) for the Hospital Fiscal Periods beginning on or after January 1, 1990 and before October 1, 1990. The data set includes only the most current cost report (as submitted, final settled or reopened) submitted for a Medicare Certified Hospital by the Medicare Fiscal Intermediary to HCFA. This data set is updated by the end of each calendar quarter and is available on the last day of the following month.

Price: \$660.00

12. PPS-VI Capital Data Set

The PPS-VI Capital Data Set contains selected data for capital-related costs, interest expense and related information

and complete balance sheet data from the Medicare Hospital Cost Report (Form 2552-85) for the Hospital Fiscal Periods beginning on or after October 1, 1988 and before January 1, 1989 and (Form 2552-89) for the Hospital Fiscal Periods beginning on or after January 1, 1989 and before October 1, 1989. The data set includes only the most current cost report (as submitted, final settled or reopened) submitted for a Medicare Certified Hospital by the Medicare Fiscal Intermediary to HCFA. This data set is updated at the close of each calendar quarter and is available on the last day of the following month.

Price: \$660.00

13. PPS-VII Capital Data Set

The PPS-VII Capital Data Set contains selected data for capital related costs, interest expense and related information and complete balance sheet data from the Medicare Hospital Cost Report (Form 2552-85) for the Hospital Fiscal Periods beginning on or after October 1, 1989 and before October 1, 1990. The data set includes only the most current cost report (as submitted, final settled or reopened) submitted for a Medicare Certified Hospital by the Medicare Fiscal Intermediary to HCFA. This data set is updated at the close of each calendar quarter and is available on the last day of the following month.

Price: \$660.00

14. Provider-Specific File

This file is a component of the PRICER program used in an intermediary's system to compute individual DRG payments. The file contains records for all prospective payment system eligible hospitals, including hospitals in waiver States, and data elements used in the prospective payment system recalibration process and related activities. Beginning with December 1988, the individual records were enlarged to include pass-through per diems and other elements. Beginning with December 1991, the individual records were enlarged to include elements related to the capital prospective payment system.

Periods Available: December 1987, 1988, 1989, 1990, and 1991 updates

Price: \$460.00

15. HCFA Medicare Case-Mix Index File (3½" Diskette)

This file contains the hospital provider number and the Medicare case-mix index as published in each year's update of the Medicare Hospital Prospective Payment System. The case-mix index is a measure of the costliness

of cases treated by a hospital relative to the cost of the national average of all Medicare hospital cases, using DRG weights as a measure of relative costliness of cases.

Periods Available: FY 1985 through FY 1991

Price: \$130.00

16. Table 5 DRG (3½" Diskette)

This file contains a listing of DRGs, DRG narrative description, relative weight, geometric mean, length of stay, and day outlier trim points as published in the Federal Register.

Periods Available: FY 1993 PPS Update

Price: \$130.00

17. AOR/BOR File (3½" Diskette)

This diskette contains data used to develop the DRG relative weights. It contains mean, maximum, minimum, standard deviation and coefficient of variation statistics by DRG for length of stay and standardized charges. The BOR tables are "Before Outliers Removed" and the AOR is "After Outliers Removed." (This refers to statistical outliers, not payment outliers.)

Periods Available: FY 1993 PPS Update

Price: \$130.00

For further information concerning these data tapes, contact Mary R. White at (410) 597-3671.

In addition, certain other data, such as area wage data and data used to construct the Puerto Rico standardized amounts, are available in hard copy format. Commenters interested in examining hard copy data should contact Lana Price at (410) 966-4535.

We realize that commenters may be interested in obtaining data other than those we have discussed above. These commenters should direct their requests to Lana Price at the number provided above.

Finally, in lieu of obtaining data through the mail, certain data may also be available for inspection at the central office of the Health Care Financing Administration in Baltimore, Maryland. Commenters interested in obtaining more information about this alternative for reviewing data should also contact Lana Price.

C. Public Comments

Because of the large number of items of correspondence we normally receive on a proposed rule, we are not able to acknowledge or respond to them individually. However, in preparing the final rule, we will consider all comments concerning the provisions of this proposed rule that we receive by the date and time specified in the "Dates" section of this preamble and respond to

those comments in the preamble to that rule. We emphasize that, given the statutory requirement under section 1886(e)(5) of the Act that our final rule for FY 1993 be published by September 1, 1992, we will consider only those comments that deal specifically with the matters discussed in this proposed rule.

List of Subjects

42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR chapter IV is amended as follows:

CHAPTER IV—HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

SUBCHAPTER B—MEDICARE PROGRAMS

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

I. Part 412 is amended as follows:

A. The authority citation for part 412 continues to read as follows:

Authority: Sections 1102, 1815(e), 1871, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395g(e), 1395hh, and 1395ww).

Subpart A—General Provisions

B. Subpart A is amended as follows:

1. Section 412.1 is revised to read as follows:

§ 412.1 Scope of part.

(a) *Purpose.* This part implements sections 1886(d) and (g) of the Act by establishing a prospective payment system for the operating costs of inpatient hospital services furnished to Medicare beneficiaries in cost reporting periods beginning on or after October 1, 1983 and a prospective payment system for the capital-related costs of inpatient hospital services furnished to Medicare beneficiaries in cost reporting periods beginning on or after October 1, 1991. Under these prospective payment systems, payment for the operating and capital-related costs of inpatient hospital services furnished by hospitals subject to the systems (generally, short-term, acute-care hospitals) is made on the basis of prospectively determined rates and applied on a per discharge basis. Payment for other costs related to inpatient hospital services, organ acquisition costs incurred by hospitals

with approved organ transplantation centers, and direct costs of medical education) is made on a reasonable cost basis. Additional payments are made for outlier cases, bad debts, indirect medical education costs, and for serving a disproportionate share of low-income patients. Under either prospective payment system, a hospital may keep the difference between its prospective payment rate and its operating or capital-related costs incurred in furnishing inpatient services, and the hospital is at risk for inpatient operating or inpatient capital-related costs that exceed its payment rate.

(b) *Summary of content.* This subpart describes the basis of payment for inpatient hospital services under the prospective payment systems, and sets forth the general basis of these systems. Subpart B of this part sets forth the classifications of hospitals that are included in and excluded from the prospective payment systems, and sets forth requirements governing the inclusion or exclusion of hospitals in the systems as a result of changes in their classification. Subpart C of this part sets forth certain conditions that must be met for a hospital to receive payment under the prospective payment systems. Subpart D of this part sets forth the basic methodology by which prospective payment rates for inpatient operating costs are determined. Subpart E of this part describes the transition rate-setting methods that are used to determine transition payment rates for inpatient operating costs during the first four years of the prospective payment system. Subpart F of this part sets forth the methodology for determining additional payments for outlier cases. Subpart G of this part sets forth rules for special treatment of certain facilities under the prospective payment system for inpatient operating costs. Subpart H of this part describes the types, amounts, and methods of payment to hospitals under the prospective payment system for inpatient operating costs. Subpart K of this part describes how the prospective payment system for inpatient operating costs is implemented for hospitals located in Puerto Rico. Subpart L of this part sets forth the procedures and criteria concerning application from hospitals to the Medicare Geographic Classification Review Board for geographic redesignation. Subpart M of this part describes how the prospective payment system for inpatient capital-related costs is implemented effective with cost reporting periods beginning on or after October 1, 1991.

2. Section 412.2 is amended as follows:

a. Paragraphs (a), (b)(1), and the introductory text of paragraph (b)(2) are revised;

b. Paragraphs (d) and (e) are redesignated as paragraphs (e) and (f), and a new paragraph (d) is added;

c. The introductory text of newly redesignated paragraph (e) and newly redesignated paragraphs (e)(1) and (e)(2) are revised;

d. The introductory text of newly redesignated paragraph (f) and newly redesignated paragraphs (f)(2), (f)(3), and (f)(6) are revised;

e. Newly redesignated paragraph (f)(7) is redesignated as paragraph (f)(8), and a new paragraph (f)(7) is added.

§ 412.2 Basis of payment.

(a) *Payment on a per discharge basis.* Under both the inpatient operating and inpatient capital-related prospective payment systems, hospitals are paid a predetermined amount per discharge for inpatient hospital services furnished to Medicare beneficiaries. The prospective payment rate for each discharge (as defined in § 412.4) is determined according to the methodology described in subpart D, E, or G of this part, as appropriate, for operating costs, and according to the methodology described in subpart M of this part for capital-related costs. An additional payment is made for both inpatient operating and inpatient capital-related costs, in accordance with subpart F of this part, for cases that have an atypically long length of stay or are extraordinarily costly to treat.

(b) *Payment in full.* (1) The prospective payment amount paid for inpatient hospital services is the total Medicare payment for the inpatient operating costs (as described in paragraph (c) of this section) and the inpatient capital-related costs (as described in paragraph (d) of this section) incurred in furnishing services covered by the Medicare program.

(2) The full prospective payment amount, as determined under subpart D, E, or G and under subpart M of this part, is made for each stay during which there is at least one Medicare payable day of care. Payable days of care, for purposes of this paragraph (b)(2) of this section include the following:

(d) *Inpatient capital-related costs.* For cost reporting periods beginning on or after October 1, 1991, the capital prospective payment system provides a payment amount for inpatient hospital capital-related costs as described in part 413, subpart G of this chapter.

(e) *Excluded costs.* The following inpatient hospital costs are excluded

from the prospective payment amounts and are paid on a reasonable cost basis:

(1) Capital-related costs for cost reporting periods beginning before October 1, 1991, and an allowance for return on equity, as described in §§ 413.130 and 413.157, respectively, of this chapter.

(2) Direct medical education costs for approved nursing and allied health education programs as described in § 413.85 of this chapter.

* * *

(f) *Additional payments to hospitals.* In addition to payments based on the prospective payment rates for inpatient operating costs and inpatient capital-related costs, hospitals receive payments for the following:

* * *

(2) The indirect costs of graduate medical education, as specified in subparts F and G of this part and in § 412.105 for inpatient operating costs and in § 412.322 for inpatient capital-related costs.

(3) Costs excluded from the prospective payment rates under paragraph (e) of this section, as provided in § 412.115.

* * *

(6) Serving a disproportionate share of low-income patients, as provided in § 412.106 for inpatient operating costs and § 412.320 for inpatient capital-related costs.

(7) The direct graduate medical education costs for approved residency programs in medicine, osteopathy, dentistry, and podiatry as described in § 413.86 of this chapter.

* * *

§ 412.4 [Amended]

3. In § 412.4, the term "prospective payment system" is revised to read "prospective payment systems" wherever it appears; and in paragraph (d)(1), the term "prospective payment rate" is changed to read "prospective payment rates", and the phrase "subparts D and E" is revised to read "subparts D, E, and M" wherever it appears.

4. Section 412.6 is revised to read as follows:

§ 412.6 Cost reporting periods subject to the prospective payment systems.

(a) *Initial cost reporting period for each prospective payment system.* (1) Each subject hospital is paid under the prospective payment system for operating costs for inpatient hospital services effective with the hospital's first cost reporting period beginning on or after October 1, 1983 and for inpatient

capital-related costs effective with the hospital's first cost reporting period beginning on or after October 1, 1991.

(2) The hospital is paid the applicable prospective payment rate for inpatient operating costs and capital-related costs for each discharge occurring on or after the first day of its first cost reporting period subject to the applicable prospective payment system.

(3) If a discharged beneficiary was admitted to the hospital before the first day of the hospital's first cost reporting period subject to the prospective payment system for inpatient operating costs, the reasonable costs of services furnished before that day are paid under the cost reimbursement provisions of part 413 of this chapter. For such discharges, the amount otherwise payable under the applicable prospective payment rate is reduced by the amount paid on a reasonable cost basis for inpatient hospital services furnished to that beneficiary during the hospital stay. If the amount paid under reasonable cost exceeds the inpatient operating prospective payment amount, the reduction is limited to the inpatient operating prospective payment amount.

(b) *Changes in cost reporting periods.* HCFA recognizes a change in a hospital's cost reporting period made after November 30, 1982 only if the change has been requested in writing by the hospital and approved by the intermediary in accordance with § 413.24(f)(3) of this chapter.

5. Section 412.8 is revised to read as follows:

§ 412.8 Publication of schedules for determining prospective payment rates.

(a) *Initial prospective payment rates—(1) For inpatient operating costs.* Initial prospective payment rates for inpatient operating costs (for the period October 1, 1983 through September 30, 1984) were determined in accordance with documents published in the *Federal Register* on September 1, 1983 (48 FR 39838), and January 3, 1984 (49 FR 324).

(2) *For inpatient capital-related costs.* Initial prospective payment rates for inpatient capital-related costs (for the period October 1, 1991 through September 30, 1992) were determined in accordance with the final rule published in the *Federal Register* on August 30, 1991 (56 FR 43196).

(b) *Annual publication of schedule for determining prospective payment rates.* (1) for cost reporting periods beginning after September 30, 1984, HCFA publishes an annual document setting forth the methodology and data used, including the percentage increase factor, to determine prospective payment rates for inpatient operating costs and (for

cost reporting periods beginning after September 30, 1991) for inpatient capital-related costs applicable to discharges occurring during the Federal fiscal year beginning on or after October 1 of that year.

(2) HCFA proposes changes in the methods, amounts, and factors used to determine inpatient prospective payment rates in a *Federal Register* document published for public comment not later than the May 1 before the beginning of the Federal fiscal year in which the proposed changes would apply.

(3) HCFA publishes a *Federal Register* document setting forth final methods, amounts, and factors for determining inpatient prospective payment rates not later than the September 1 before the Federal fiscal year in which the rates would apply.

§ 412.10 [Amended]

6. In § 412.10(a), the phrase "DRG changes will be effective" is revised to read "DRG changes are effective".

C. Subpart B is amended as follows:

1. The heading of subpart B is revised to read as follows:

Subpart B—Hospital Services Subject to and Excluded From the Prospective Payment Systems for Inpatient Operating Costs and Inpatient Capital-Related Costs

§ 412.20 [Amended]

2. In § 412.20, including the heading, the term "prospective payment system" is revised to read "prospective payment systems" wherever it appears. In § 412.20(b)(1), remove the phrase ", and § 412.32" and add the word "and" before "§ 412.29".

3. In § 412.22, in paragraph (a), the phrase "A hospital will be excluded from the prospective payment system" is revised to read "A hospital is excluded from the prospective payment systems"; in paragraph (b), the phrase "will be subject to the ceiling" is revised to read "are subject to the ceiling" and the phrase "and § 412.32" is removed; and a new paragraph (d) is added to read as follows:

§ 412.22 Excluded hospitals and hospital units: General rules.

(d) *Changes in hospitals' status.* For purposes of exclusion from the prospective payment systems under this subpart, the status of each currently participating hospital (excluded or not excluded) is determined at the beginning of each cost reporting period and is effective for the entire costs reporting period. Any changes in the status of the

hospital are made only at the start of a cost reporting period.

4. In § 412.23, the term "prospective payment system" is revised to read "prospective payment systems" wherever it appears; paragraph (b)(8) is revised; and paragraph (c) is removed and reserved to read as follows:

§ 412.23 Excluded hospitals: Classifications.

(b) * * *

(8) A hospital that seeks exclusion as a rehabilitation hospital for the first full 12-month cost reporting period that occurs after it becomes a Medicare participating hospital may provide a written certification that the inpatient population it intends to serve meets the requirements of paragraph (b)(2) of this section, instead of showing that it has treated such a population during its most recent 12-month cost reporting period. The written certification is also effective for any cost reporting period of not less than one month and not more than 13 months occurring between the date the hospital began participating in Medicare and the start of the hospital's regular 12-month cost reporting period.

5. In § 412.25, the term "prospective payment system" is revised to read "prospective payment systems" wherever it appears; the introductory text of paragraph (a) is revised; a new paragraph (a)(13) is added; in paragraph (b), the phrase "will remain the same" is revised to read "remains the same"; and a new paragraph (c) is added to read as follows:

§ 412.25 Excluded distinct part hospital units: Common requirements.

(a) *Basis for exclusion.* In order to be excluded from the prospective payment systems, a distinct part psychiatric or rehabilitation unit must meet the following requirements:

(13) As of the first day of the first cost reporting period for which all other exclusion requirements are met, the unit is fully equipped and staffed and is capable of providing hospital inpatient psychiatric or rehabilitation care regardless of whether there are any inpatients in the unit on that date.

(c) *Changes in the status of hospital units.* For purposes of exclusion from the prospective payment systems under this section, the status of each hospital unit (excluded or not excluded) is determined at the beginning of each cost reporting period and is effective for the entire cost reporting period. Any

changes in the status of a unit are made only at the start of a cost reporting period. If a unit is added to a hospital after the start of a cost reporting period, it cannot be excluded from the prospective payment systems before the start of the hospital's next cost reporting period.

§ 412.27 [Amended]

6. In the introductory text of § 412.27, the term "prospective payment system" is revised to read "prospective payment systems".

§ 412.29 [Amended]

7. In the introductory text of § 412.29, the term "prospective payment system" is revised to read "prospective payment systems".

8. In § 412.30, paragraph (a) is revised and, in paragraph (c), the term "prospective payment system" is revised to read "prospective payment systems" to read as follows:

§ 412.30 Exclusion of new distinct part rehabilitation units and expansion of units already excluded.

(a) *New units.* (1) A hospital that seeks exclusion of a new rehabilitation unit may provide a written certification that the inpatient population the hospital intends the unit to serve meets the requirements of § 412.23(b)(2) instead of showing that the unit has treated such a population during the hospital's most recent 12-month cost reporting period.

(2) If a hospital that is currently participating in Medicare has not previously sought exclusion for any rehabilitation unit and has obtained approval for added bed capacity under State licensure and under its Medicare certification, it may identify the new beds as a new rehabilitation unit for the first full 12-month cost reporting period during which the beds are used to furnish inpatient care. A unit of a currently participating hospital that includes some beds that were previously licensed and certified and some new beds is recognized as a new rehabilitation unit only if more than one-half of the beds are new.

(3) If a hospital that has not previously participated in the Medicare program seeks exclusion of a rehabilitation unit, it may designate certain beds as a new rehabilitation unit for the first full 12-month cost reporting period that occurs after it becomes a Medicare participating hospital. The written certification described in paragraph (a)(1) of this section also is effective for any cost reporting period of not less than 1 month and not more than 13 months occurring between the date

the hospital began participating in Medicare and the start of the hospital's regular 12-month cost reporting period.

(4) For purposes of paragraph (a) of this section, a hospital that has undergone a change of ownership or leasing as defined in § 489.18 of this chapter is not considered to have participated previously in the Medicare program.

§ 412.32 [Removed]

9. Section 412.32 is removed.

D. Subpart C is amended as follows:

1. The heading for subpart C is revised to read as follows:

Subpart C—Conditions for Payment Under the Prospective Payment Systems for Inpatient Operating Costs and Inpatient Capital-Related Costs

§ 412.40 [Amended]

2. In § 412.40(a), the term "prospective payment system" is revised to read "prospective payment systems".

§ 412.42 [Amended]

3. In § 412.42, the term "prospective payment system" is revised to read "prospective payment systems" in paragraph (a) and in the introductory text of paragraph (b).

§ 412.46 [Amended]

4. In § 412.46, in paragraph (d)(1), the phrase "The PRO will review" is revised to read "The PRO reviews"; in paragraph (e)(1), the phrase "the Medicare claim will be appropriately changed" is revised to read "the Medicare claim is appropriately changed"; and in paragraph (e)(2), the phrase "the PRO will change the coding and assign the appropriate DRG" is revised to read "the PRO changes the coding and assigns the appropriate DRG".

§ 412.48 [Amended]

5. In § 412.48(c), the term "prospective payment system" is revised to read "prospective payment systems".

§ 412.50 [Amended]

6. In § 412.50(a), the phrase "The applicable payments made under the prospective payment system, as described in subpart H" is revised to read "The applicable payments made under the prospective payment systems, as described in subparts H and M".

§ 412.52 [Amended]

7. In § 412.52, the term "prospective payment system" is revised to read "prospective payment systems".

E. Subpart D is amended as follows:

1. The heading for subpart D is revised to read as follows:

Subpart D—Basic Methodology for Determining Prospective Payment Federal Rates for Inpatient Operating Costs

§ 412.60 [Amended]

2. In § 412.60, in paragraphs (a) and (c) introductory text, the phrase "HCFA will establish" is revised to read "HCFA establishes"; in paragraph (b), the phrase "HCFA will assign" is revised to read "HCFA assigns"; in paragraph (c)(1), the phrase "The classification of a particular discharge, will, as appropriate, be based," is revised to read "The classification of a particular discharge is based, as appropriate,"; in paragraphs (c)(2) and (c)(3), the phrase "will be" is revised to read "is"; and in paragraph (c)(3), the phrase "will provide" is revised to read "provides".

3. In § 412.62, the section heading is revised; paragraph (a) is revised; in paragraph (b), the heading is revised, and the phrase "HCFA will determine" is revised to read "HCFA determines"; in paragraph (c) introductory text, the phrase "HCFA will update" is revised to read "HCFA updates"; in paragraph (d) introductory text, the phrase "HCFA will standardize" is revised to read "HCFA standardizes"; in paragraph (e) introductory text, the phrase "HCFA will compute" is revised to read "HCFA computes"; and the heading and the introductory text of paragraph (j) are revised to read as follows:

§ 412.62 Federal rates for inpatient operating costs for fiscal year 1984.

(a) *General rule.* HCFA determines national adjusted DRG prospective payment rates for operating costs, for each inpatient hospital discharge in fiscal year 1984 involving inpatient hospital services of a hospital in the United States subject to the prospective payment system under Subpart B of this part, and determines regional adjusted DRG prospective payment rates for inpatient operating costs for such discharges in each region, for which payment may be made under Medicare Part A. Such rates are determined for hospitals located in urban or rural areas within the United States and within each such region, respectively, as described in paragraphs (b) through (k) of this section.

(b) *Determining allowable individual hospital inpatient operating costs.*

(j) *Computing Federal rates for inpatient operating costs for urban and rural hospitals in the United States and*

in each region. For each discharge classified within a DRG, HCFA establishes a national prospective payment rate for inpatient operating costs and a regional prospective payment rate for inpatient operating costs for each region, as follows:

4. Section 412.63 is amended by revising the section heading, paragraph (a)(1), the introductory text of paragraph (o) and paragraph (p)(1); by revising in paragraph (a)(2) the phrase "Each such rate will be" to read "Each such rate is"; by revising in paragraph (b)(2)(ii) the phrase "will receive the lower" to read "receives the lower"; and by revising in paragraph (n)(1) the phrase "HCFA will adjust" to read "HCFA adjusts" to read as follows:

§ 412.63 Federal rates for inpatient operating costs for fiscal years after Federal fiscal year 1984.

(a) *General rule.* (1) HCFA determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in a Federal fiscal year after fiscal year 1984 involving inpatient hospital services of a hospital in the United States subject to the prospective payment system, and determines a regional adjusted prospective payment rate for operating costs for such discharges in each region, for which payment may be made under Medicare Part A.

(o) Computing Federal rates for inpatient operating costs for large urban, other urban, and rural hospitals. For each discharge classified within a DRG, HCFA establishes for the fiscal year a national prospective payment rate and a regional prospective payment rate for inpatient operating costs, for each region, as follows:

(p) *Adjusting for different area wage levels.* (1) HCFA adjusts the proportion (as estimated by HCFA from time to time) of Federal rates for inpatient operating costs computed under paragraph (j) of this section that are attributable to wages and labor-related costs for area differences in hospital wage levels by a factor (established by HCFA based on survey data) reflecting the relative level of hospital wages and wage-related costs in the geographic area (that is, urban or rural area as determined under the provisions of paragraph (b) of this section) of the hospital compared to the national average level of hospital wages and wage-related costs.

F. Subpart E is amended as follows:

1. The heading for subpart E is revised to read as follows:

Subpart E—Determination of Transition Period Payment Rates for the Prospective Payment System for Inpatient Operating Costs

2. Section 412.70 is revised to read as follows:

§ 412.70 General description.

For discharges occurring on or after April 1, 1988 and before October 1, 1993, payments to a hospital are based on the greater of the national average standardized amount or the sum of 85 percent of the national average standardized amount and 15 percent of the average standardized amount for the region in which the hospital is located.

3. Section 412.71 is amended by revising the section heading; by revising paragraph (c)(1) introductory text; by revising the phrase "will decide" to read "decides" in paragraph (c)(2); and by revising the phrase "will use" to read "uses" in paragraph (d) to read as follows:

§ 412.71 Determination of base-year inpatient operating costs.

(c) *Hospital's request for adjustment of base-year inpatient operating costs.* (1) Before the date it becomes subject to the prospective payment system for inpatient operating costs, a hospital may request the intermediary to further adjust its estimated base-period costs to take into account the following:

§ 412.73 [Amended]

4. In § 412.73, paragraph (d)(1) is amended by revising the phrase "HCFA will adjust" to read "HCFA adjusts" and by revising the phrase "will be based on a factor" to read "is based on a factor"; in paragraph (d)(2), by revising the phrase "HCFA will adjust" to read "HCFA adjusts" and in paragraph (e) by revising the phrase "cost per discharge will be multiplied" to read "cost per discharge is multiplied".

§ 412.74 [Removed]

5. Section 412.74 is removed.

6. Section 412.75 is amended by revising the section heading; in paragraph (b), by revising the phrase "considered to be a discharge" to read "considered to be a discharge" and by combining the concluding paragraph with paragraph (b); and in paragraph (e), by revising the phrase "cost per discharge will be multiplied" to read "cost per discharge is multiplied" to read as follows:

§ 412.75 Determination of the hospital-specific rate for inpatient operating costs based on a Federal fiscal year 1987 base period.

§ 412.76 [Amended]

6. Section 412.76 is amended by revising the phrase "costs will be adjusted" to read "costs are adjusted" and by revising the phrase "HCFA will recover" to read "HCFA recovers".

G. Subpart F is amended as follows:

1. In § 412.80, the introductory text of paragraph (a)(1)(ii) is republished; paragraphs (a)(1)(ii) (A) and (c) are revised; and in paragraph (a)(2), the phrase "HCFA will provide cost outlier payments" is revised to read "HCFA provides cost outlier payments" to read as follows:

§ 412.80 General provisions.

(a) *Basic rule.* (1) * * *
(ii) The beneficiary's length of stay does not exceed criteria established under paragraph (a)(1)(i) of this section, but the hospital's charges for covered services furnished to the beneficiary, adjusted to cost by applying a cost-to-charge ratio as described in § 412.84(h), exceed the greater of the following:

(A) A fixed dollar amount (adjusted for geographic variation in costs) as specified by HCFA.

(c) *Relation to hospitals that incur indirect costs for graduate medical education programs and that serve a disproportionate share of low-income patients.* The outlier payment amounts are included in total DRG revenue for purposes of determining payments for hospitals that incur indirect costs for graduate medical education programs under § 412.105 and to hospitals that serve a disproportionate share of low-income patients under § 412.106.

2. In § 412.82, paragraph (c) is revised; paragraph (d) is removed; and paragraph (e) is redesignated as paragraph (d) to read as follows:

§ 412.82 Payment for extended length-of-stay cases (day outliers).

(c) Except as provided in § 412.86, the per diem payment made under paragraph (a) of this section is derived by taking 55 percent of the average per diem payment for the applicable DRG, as calculated by dividing the Federal prospective payment rate for inpatient operating costs and inpatient capital-related costs determined under Subpart D of this part by the arithmetic mean length-to-stay for that DRG.

§ 412.84 [Amended]

3. In § 412.84(d), the phrase "through this review will be denied" is revised to read "through this review are denied" and the phrase "these services will be recovered" is revised to read "these services are recovered".

H. Subpart G is amended as follows:

1. The heading of subpart G is revised to read as follows:

Subpart G—Special Treatment of Certain Facilities under the Prospective Payment System for Inpatient Operating Costs

2. Section 412.90 is revised to read as follows:

§ 412.90 General rules.

(a) *Sole community hospitals.* HCFA may adjust the prospective payment rates for inpatient operating costs determined under subpart D or E of this part if a hospital, by reason of factors such as isolated location, weather conditions, travel conditions, or absence of other hospitals, is the sole source of inpatient hospital services reasonably available in a geographic area to Medicare beneficiaries. If a hospital meets the criteria for such an exception under § 412.92(a), its prospective payment rates for inpatient operating costs are determined under § 412.92(d).

(b) *Referral center.* HCFA may make an adjustment to the prospective payment rates for inpatient operating costs determined under subpart D or E of this part if a hospital acts as a referral center for patients transferred from other hospitals. Criteria for identifying such referral centers are set forth in § 412.96.

(c) *Christian Science Sanatoria.* HCFA adjusts the prospective payment rates for inpatient operating costs determined under subpart D or E of this part if a hospital is a Christian Science sanatorium. Such a sanatorium's prospective payment rates are determined in accordance with § 412.98.

(d) *Kidney acquisition costs incurred by hospitals approved as renal transplantation centers.* HCFA pays for kidney acquisition costs incurred by renal transplantation centers on a reasonable cost basis. The criteria for this special payment provision are set forth in § 412.100.

(e) *Hospitals that are located in urban areas and that are reclassified as rural.* HCFA adjusts the rural Federal payment amounts for inpatient operating costs for hospitals reclassified as rural, as defined in § 412.62(f). The criteria for this adjustment are set forth in § 412.102.

(f) *Hospitals that have a high percentage of ESRD beneficiary*

discharges. HCFA makes an additional payment to a hospital if ten percent or more of its total Medicare discharges in a cost reporting period beginning on or after October 1, 1984 are ESRD beneficiary discharges. In determining ESRD discharges, discharges in DRG Nos. 302, 316, and 317 are excluded. The criteria for this additional payment are set forth in § 412.104.

(g) *Hospitals that incur indirect costs for graduate medical education programs.* HCFA makes an additional payment for inpatient operating costs to a hospital for indirect medical education costs attributable to an approved graduate medical education program. The criteria for this additional payment are set forth in § 412.105.

(h) *Hospitals that serve a disproportionate share of low-income patients.* For discharges occurring on or after May 1, 1986, HCFA makes an additional payment for inpatient operating costs to hospitals that serve a disproportionate share of low-income patients. The criteria for this additional payment are set forth in § 412.106.

(i) *Medicare-dependent, small rural hospitals.* For cost reporting periods beginning on or after April 1, 1990 and ending before April 1, 1993, HCFA adjusts the prospective payment rates for inpatient operating costs determined under subparts D and E of this part if a hospital is classified as a Medicare-dependent, small rural hospital. Criteria for identifying these hospitals are set forth in § 412.108.

3. In § 412.92, in paragraphs (b)(1)(iv) and (b)(1)(v), the phrase "will review" is revised to read "reviews"; in paragraph (b)(3), the phrase "will remain" is revised to read "remains"; in paragraph (b)(5), the phrase "will be" is revised to read "is"; and the heading of paragraph (d), and paragraphs (e)(3) introductory text and (e)(3)(i)(B) are revised to read as follows:

§ 412.92 Special treatment: Sole community hospitals.

(d) *Determining prospective payment rates for inpatient operating costs for sole community hospitals.*

(e) *Additional payments to sole community hospitals experiencing a significant volume decrease.*

(3) The intermediary determines a lump sum adjustment amount not to exceed the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating

costs (including outlier payments for inpatient operating costs determined under Subpart F of this part and additional payments made for inpatient operating costs for hospitals that serve a disproportionate share of low-income patients as determined under § 412.106 and for indirect medical education costs as determined under § 412.105).

(i) * * *

(B) The hospital's fixed (and semi-fixed) costs, other than those costs paid on a reasonable cost basis under part 413 of this chapter; and

4. In § 412.96, the reference "§ 412.118(b)" in paragraph (b)(1) introductory text is revised to read "§ 412.105(b)"; the reference "§ 412.118" in paragraph (c)(1)(ii) is revised to read "§ 412.105"; and paragraph (d) is revised to read as follows:

§ 412.96 Special treatment: Referral centers.

(d) *Payment to rural referral centers.* Effective for discharges occurring on or after April 1, 1988, a hospital that is located in a rural area and meets the criteria of paragraphs (b)(1), (b)(2) or (c) of this section is paid prospective payments for inpatient operating costs per discharge based on the applicable other urban payment rates as determined in accordance with § 412.63, as adjusted by the hospital's area wage index.

5. In § 412.98, paragraphs (a) and (b) are revised to read as follows:

§ 412.98 Special treatment: Christian Science Sanatoria

(a) *General rule.* If a Christian Science Sanatorium is not excluded from the prospective payment systems under subpart B of this part, HCFA pays, for inpatient hospital services furnished to be beneficiary by that sanatorium, a predetermined fixed amount per discharge based on the sanatorium's historical inpatient operating costs per discharge.

(b) *Prospective payment rates.* For cost reporting periods beginning on or after October 1, 1983, the sanatorium's prospective payment rate for inpatient operating costs equals the amount that would constitute the sanatorium's target amount under § 413.40(c)(4) of this chapter if the institution were subject to the rate of increase ceiling specified in § 413.40 of this chapter instead of the prospective payment systems. This amount is not adjusted for the DRG weighting factor.

6. In § 412.100, paragraphs (a)(1) and (a)(2) are revised to read as follows:

§ 412.100 Special treatment: Renal transplantation centers.

(a) *Adjustments for renal transplantation centers.*

(1) HCFA adjusts the prospective payment rates for inpatient operating costs determined under subparts D and E of this part for hospitals approved as renal transplantation centers (described at §§ 405.2170 and 405.2171 of this chapter) to remove the estimated net expenses associated with kidney acquisition.

(2) Kidney acquisition costs are treated apart from the prospective payment rate for inpatient operating costs, and payment to the hospital is adjusted in each reporting period to reflect an amount necessary to compensate the hospital for reasonable expenses of kidney acquisition.

§ 412.102 [Amended]

7. In the introductory text of § 412.102, the phrase "rural Federal payment amount" is revised to "rural Federal payment amount for operating costs".

§ 412.104 [Amended]

8. In § 412.104, in paragraph (a), the phrase "will provide" is revised to read "provides"; in the introductory text of paragraph (b) and in paragraph (b)(4) the phrase "will be" is revised to read "is"; and in paragraph (b)(5), the phrase "will be equal to" is revised to read "equals".

9. In § 412.105, the section heading and the introductory text to the section are revised; the introductory text of paragraph (a) is reprinted; and paragraphs (a)(2) and (e) are revised to read as follows:

§ 412.105 Special treatment: Hospitals that incur indirect costs for graduate medical education programs.

HCFA makes an additional payment to hospitals for indirect medical education costs using the following procedures:

(a) *Basic data.* HCFA determines the following for each hospital:

(2) The hospital's total DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs including outlier payments for inpatient operating costs determined under subpart F of this part, but excluding additional payments made under the provisions of this subpart.

(e) *Determination of payment amount.* Each hospital's indirect medical education payment under the prospective payment system for inpatient operating costs is determined by multiplying the total DRG revenue for inpatient operating costs, as determined under paragraph (a)(2) of this section, by the applicable education adjustment factor derived in paragraph (d) of this section.

10. In § 412.106, the reference "§ 412.118(b)" in paragraph (a)(1)(i) is revised to read "§ 412.105(b)"; the reference "§ 412.118" in paragraph (a)(2)(ii) is revised to read "412.105"; in paragraphs (d)(2)(i)(B)(1) and (2) the date "January 1, 1993" is revised to read "October 1, 1993"; and paragraphs (a)(2) and (d)(1) are revised to read as follows:

§ 412.106 Special treatment: Hospitals that serve a disproportionate share of low-income patients.

(a) *General considerations.*

(2) The payment adjustment is applied to the hospital's total DRG revenues for inpatient operating costs.

(i) A hospital's total DRG revenues for inpatient operating costs are determined on the basis of DRG-adjusted prospective payment rates for inpatient operating costs or, for transition period payments under subpart B of this part, on the basis of the Federal portion of the hospital's payment rates.

(ii) For purposes of this section, total DRG revenues for inpatient operating costs include outlier payments for inpatient operating costs under subpart F of this part, but exclude additional payments made under this subpart.

(d) *Payment adjustment—(1) Method of adjustment.* If a hospital serves a disproportionate number of low-income patients, its total DRG revenues for inpatient operating costs are increased by an adjustment factor as specified in paragraph (d)(2) of this section.

10. In § 412.108, paragraph (a)(1)(i) the reference "§ 412.118(b)" is revised to read "§ 412.105(b)"; in paragraph (d)(3)(i)(B) the term "reimbursed" is revised to read "paid"; and paragraphs (c) and (d)(3) introductory text are revised to read as follows:

§ 412.108 Special treatment: Medicare-dependent, small rural hospitals.

(c) *Payment methodology.* A hospital that meets the criteria in paragraph (a) of this section is paid for its inpatient operating costs based on whichever of the following amounts yields the

greatest aggregate payment for the cost reporting period:

(d) *Additional payments to hospitals experiencing a significant volume decrease.*

(3) The intermediary determines a lump sum adjustment amount not to exceed the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs (including outlier payments for inpatient operating costs determined under Subpart F of this part and additional payments made for inpatient operating costs hospitals that serve a disproportionate share of low-income patients as determined under § 412.106 and for indirect medical education costs as determined under § 412.105).

1. Subpart H is amended as follows:

1. The heading of subpart H is revised to read as follows:

Subpart H—Payments to Hospitals under the Prospective Payment Systems

§ 412.110 [Amended]

2. In § 412.110, the phrase "prospective payment system" is revised to read "prospective payment systems".

3. In § 412.112, the introductory text of the section and paragraph (a) are revised to read as follows:

§ 412.112 Payments determined on a per case basis.

A hospital is paid the following amounts on a per case basis:

(a) The appropriate prospective payment rate for inpatient operating costs for each discharge as determined in accordance with subparts D, E, and G of this part.

4. In § 412.113, paragraph (a)(2)(i) introductory text is republished and paragraph (a)(2)(i)(E) is revised to read as follows:

§ 412.113 Other payments.

(a) *Capital-related costs.*

(2) *Reduction to capital-related payments.* (i) Except for sole community hospitals as defined in § 412.92, the amount of capital-related payments for cost reporting periods beginning before October 1, 1991 (including a return on equity capital as provided under

§ 413.157 of this chapter) is reduced by—

(E) Ten percent for payments attributable to portions of cost-reporting periods occurring on or after October 1, 1991 and before the beginning of the hospital's first cost-reporting period beginning on or after October 1, 1991.

§ 412.115. [Amended]

5. In § 412.115, in paragraph (a), the phrase "An additional payment will be made" is revised to read "An additional payment is made".

§ 412.120 [Amended]

6. In § 412.120 in paragraph (a), the phrase "payments otherwise payable to a hospital will be reduced" is revised to read "payments otherwise payable to a hospital are reduced"; and in the introductory text of paragraph (b) the phrase "the Medicare payment will be determined" is revised to read "the Medicare payment is determined".

§ 412.130 [Amended]

7. In § 412.130, in paragraphs (b)(1) and (b)(2), the phrase "prospective payment system" is revised to read "prospective payment systems".

J. Subpart K is amended as follows:

1. The heading of subpart K is revised to read as follows:

Subpart K—Prospective Payment System for Inpatient Operating Costs for Hospitals Located in Puerto Rico

2. Section 412.200 is revised to read as follows:

§ 412.200 General provisions.

Beginning with discharges occurring on or after October 1, 1987, hospitals located in Puerto Rico are subject to the rules governing the prospective payment system for inpatient operating costs. Except as provided in this subpart, the provisions of subparts A, B, C, F, G, and H of this part apply to hospitals located in Puerto Rico. Except for § 412.60, which deals with DRG classification and weighting factors, the provisions of subparts D and E of this part, which describe the methodology used to determine prospective payment rates for inpatient operating costs for hospitals, do not apply to hospitals located in Puerto Rico. Instead, the methodology for determining prospective payment rates for inpatient operating costs for these hospitals is set forth in § 412.204 through 412.212.

3. Section 412.204 is revised to read as follows:

§ 412.204 Payments to hospitals located in Puerto Rico.

Payments for inpatient operating costs to hospitals located in Puerto Rico that are paid under the prospective payment system are equal to the sum of—

(a) 75 percent of the Puerto Rico prospective payment rate for inpatient operating costs, as determined under § 412.208 or § 412.210; and
(b) 25 percent of a national prospective payment rate for inpatient operating costs, as determined under § 412.212.

4. In § 412.208, paragraphs (a) and (b), and the heading of paragraph (h) are revised to read as follows:

§ 412.208 Puerto Rico rates for Federal fiscal year 1988.

(a) *General rule.* HCFA determines the Puerto Rico adjusted DRG prospective payment for inpatient operating costs for each inpatient hospital discharge occurring in Federal fiscal year 1988 for a prospective payment hospital. These rates are determined as described in paragraphs (b) through (i) of this section.

(b) *Determining target amounts.* For each hospital subject to the prospective payment system for inpatient operating costs, HCFA determines the Medicare target amount, as described in § 413.40(c) of this chapter, for the hospital's cost reporting period beginning in fiscal year 1987. Revisions in the target amounts made subsequent to establishment of the standardized amounts under paragraph (d) of this section do not affect the standardized amounts.

(h) *Computing Puerto Rico rates established under the prospective payment system for inpatient operating costs for urban and rural hospitals.*

§ 412.210 [Amended]

5. In § 412.210, in paragraphs (a)(1), (b)(3) and the introductory text of paragraph (d), the phrase "for inpatient operating costs" is inserted after the phrase "prospective payment rate".

§ 412.212 [Amended]

6. In § 412.212, paragraph (a), the phrase "national prospective payment rate" is revised to read "national prospective payment rate for inpatient operating costs".

§ 412.220 [Amended]

7. In § 412.220, introductory text for the section, the phrase "prospective payment system," is revised to read "prospective payment system for inpatient operating costs."

Subpart L—The Medicare Geographic Classification Review Board

L. Subpart L is amended as follows:

1. Section 412.230 is amended as follows:

a. The heading is revised;
b. Paragraphs (a)(1) and (a)(3) are revised;
c. New paragraphs (a)(4)(v) and (a)(5) are added;
d. In the heading of paragraph (d) and in paragraphs (d)(1) and (d)(3) introductory text, the phrase "standardized amount" is revised to read "standardized amount for inpatient operating costs";

e. In paragraph (d)(3)(ii), the phrase "prospective payment system rates for inpatient hospital services" is revised to read "prospective payment rates for inpatient operating costs";

f. Paragraph (e)(1) is revised;
g. Paragraph (e)(2) introductory text is republished and paragraph (e)(2)(i) is revised;

h. Paragraph (e)(2)(ii) introductory text is republished and paragraph (e)(2)(ii)(A) is revised.

§ 412.230 Criteria for an individual hospital seeking redesignation to another rural area or an urban area.

(a) *General—(1) Purpose.* An individual hospital may seek redesignation from a rural area to an urban area, from a rural area to another rural area, or from an urban area to another urban area for the purposes of using the other area's standardized amount for inpatient operating costs, wage index value, or both. An individual hospital may not be redesignated to more than one area.

(3) *Proximity.* Except as provided in paragraph (a)(4) of this section, to be redesignated to another rural area or an urban area, a hospital must demonstrate a close proximity to the adjacent area to which it seeks redesignation by meeting the criteria in paragraph (b) of this section, and submitting data requested under paragraph (c) of this section.

(4) *Special rules for sole community hospitals and rural referral centers.*

(v) A hospital that applies for redesignation under this section may not also apply for redesignation in the same fiscal year under paragraph (a)(2) or (a)(3) of this section.

(5) *Application of criteria.* In applying the numeric criteria contained in §§ 412.230(b)(1) and (2), (d)(2), (e)(1)(iii), and (e)(1)(iv)(A) and (B), rounding of numbers to meet the mileage or

qualifying percentage standard is not permitted.

(e) *Use of urban or other rural area's wage index*—

(1) *Criteria for use of adjacent area's wage index.* To use an adjacent area's wage index, a hospital must demonstrate the following:

(i) The hospital's incurred wage costs are comparable to hospital wage costs in an adjacent urban or other rural area;

(ii) The hospital has the necessary geographic relationship as specified in paragraphs (a) and (b) of this section;

(iii) The hospital's average hourly wage is at least 108 percent of the average hourly wage of hospitals in the area in which the hospital is located; and

(iv) One of the following conditions apply:

(A) The hospital's average hourly wage is equal to at least 84 percent of the average hourly wage of hospitals in the adjacent area to which it seeks redesignation; or

(B) The hospital's average hourly wage weighted for occupational categories is at least 90 percent of the average hourly wage of hospitals in the adjacent area to which it seeks redesignation.

(2) *Appropriate wage data.* For a wage index change, the hospital must submit appropriate data as follows:

(i) For hospital-specific data, the hospital must provide data from the HCFA hospital wage survey used to construct the wage index in effect for prospective payment purposes during the fiscal year prior to the fiscal year for which the hospital requests reclassification.

(ii) For data of other hospitals, the hospital must provide data concerning both of the following:

(A) The average hourly wage in the adjacent area, which is taken from the HCFA hospital wage survey used to construct the wage index in effect for prospective payment purposes during the fiscal year prior to the fiscal year for which the hospital requests reclassification; and

4. § 421.232, paragraph (c) is revised; paragraphs (d)(2) introductory text and (d)(2)(ii) are republished; and paragraphs (d)(2)(i) introductory text and (d)(2)(ii)(A) are revised to read as follows:

§ 421.232 *Criteria for all hospitals in a rural county seeking urban redesignation.*

(c) *Wage criteria.* In applying the following numeric criteria, rounding of

numbers to meet the qualifying percentages is not permitted.

(d) * * *

(2) *Appropriate wage data.* The hospitals must submit appropriate data as follows:

(i) For hospital-specific data, the hospitals must provide data from the HCFA wage survey used to construct the wage index in effect for prospective payment purposes during the fiscal year prior to the fiscal year for which the hospitals request reclassification.

(ii) For data for other hospitals, the hospitals must provide the following:

(A) The average hourly wage in the adjacent area, which is taken from the HCFA hospital wage survey used to construct the wage index in effect for prospective payment purposes during the fiscal year prior to the fiscal year for which the hospitals request reclassification.

5. In § 412.234, paragraph (b) is revised, and in the heading of paragraph (c) the phrase "inpatient operating costs" is inserted after the phrase "standardized amount" to read as follows:

§ 412.234 *Criteria for all hospitals in an urban county seeking redesignation to another urban area.*

(b) *Wage criteria.* In applying the following numeric criteria, rounding of numbers to meet the qualifying percentages is not permitted.

6. In § 412.273, the introductory text of paragraph (a), paragraph (a)(1) and paragraph (b) are revised; and paragraph (c) is added to read as follows:

§ 412.273 *Withdrawing an application.*

(a) *Timing of a withdrawal.* The MGCRB allows a hospital, or group of hospitals, to withdraw its application if the request for withdrawal is submitted to the MGCRB during the following time periods:

(1) At any time before the MGCRB issues a decision on the application; or

(b) *Written request only.* A request to withdraw an application must be made in writing to the MGCRB by all hospitals that are party to the application.

(c) *Appeal of the MGCRB's denial of a hospital's request for withdrawal.* (1) A hospital may appeal the MGCRB's denial of its request for withdrawal of an application to the Administrator within 15 days of the date of the notice of the denial.

(2) Within 20 days of receipt of the hospital's request for appeal, the Administrator affirms or reverses the denial.

3. In § 412.278, paragraphs (f)(1) and (f)(3) are revised; a new heading for paragraph (f) and a new paragraph (g) are added to read as follows:

§ 412.278 *Administrator's review.*

(f) *Administrator's decision.* (1) The Administrator may not receive or consider any new evidence and must issue a decision based only upon the record as it appeared before the MGCRB and comments submitted under paragraphs (b)(2), (b)(3), (b)(4), (c)(2), and (c)(3) of this section.

(3) The Administrator's decision issued under §§ 412.278(a) or (c) is the final Departmental decision, unless it is amended under § 412.278 (g). The final Departmental decision is not subject to judicial review.

(g) *Amendment of Administrator decision.* (1) Hospital's request for amendment. The hospital may request the Administrator to amend the decision for the limited purpose of correcting mathematical or computational errors, or to correct the decision if the evidence that was considered in making the decision clearly shows on its face that an error was made. The following procedure is followed:

(i) The hospital's request for amendment must be received by the Administrator within 10 days after the date the Administrator issues a decision. The request for amendment must be in writing, with a copy to HCFA.

(ii) The Administrator promptly reviews the hospital's request and amends the decision, if necessary, within 5 days following receipt of the hospital's request for amendment.

(2) *Discretionary review by the Administrator.* Within 15 days following the issuance of the Administrator's decision, the Administrator, at his or her discretion, may amend the decision to correct mathematical or computational errors, or to correct the decision if the evidence that was considered in making the decision clearly shows on its face that an error was made. The Administrator's amended decision is final and is not subject to judicial review.

Subpart M—Prospective Payment System for Inpatient Hospital Capital Costs

M. Subpart M is amended as follows:

1. In § 412.300, paragraph (b) is revised to read as follows:

§ 412.300 Scope of subpart and definition.

(b) *Definition.* For purposes of this subpart, a new hospital means a hospital that has operated (under previous or present ownership) for less than 2 years.

The following hospitals are not new hospitals:

(1) A hospital that builds new or replacement facilities at the same or another location even if coincidental with a change of ownership, a change in management, or a lease arrangement.

(2) A hospital that closes and subsequently reopens.

(3) A hospital that has been in operation for more than 2 years but has participated in the Medicare program for less than 2 years.

(4) A hospital that changes its status from a hospital that is excluded from the prospective payment systems to a hospital that is subject to the capital prospective payment system.

2. In § 412.302, the introductory text of paragraph (b) is revised; paragraphs (b)(3)(iii) and (b)(7) are added; paragraphs (c)(1)(ii), (c)(1)(iv), (c)(1)(v), (c)(1)(vii)(B) are revised; the introductory text of paragraph (c)(2)(i) is republished; and paragraph (c)(2)(i)(B) is revised to read as follows:

§ 412.302 Introduction to capital costs.

(b) *Old capital costs.* Except as provided in paragraph (c) of this section with respect to capital obligations that qualify for recognition as old capital, old capital costs are allowable capital-related costs for land and depreciable assets that were put in use for patient care on or before December 31, 1990. However, for a new hospital as defined in § 412.300(b), old capital costs are defined as those allowable capital-related costs for land and depreciable assets that were put in use for patient care on or before the later of December 31, 1990 or the last day of the hospital's base year cost reporting period under § 412.328(a)(2). Old capital costs include the following:

(3) ***

(iii) If an entire hospital is leased without assumption of the hospital's asset costs after December 31, 1990, the amount of allowable capital-related costs recognized as old capital costs is limited to the amount allowed for old capital costs in the base year or the last cost reporting period these costs were

recognized under this subpart, whichever is later.

(7) If a hospital had nonreimbursable costs applicable to an old capital asset as of December 31, 1990 that subsequently become allowable inpatient capital-related costs, the allowable costs for such an asset that are attributable to inpatient hospital services are recognized as old capital costs if a portion of the asset was in use for inpatient hospital care on December 31, 1990.

(c) *Obligated capital costs.* (1) ***
(ii) *Moveable equipment.* Moveable equipment is recognized as old capital only if all of the conditions specified in paragraph (c)(1)(i)(B) through (D) of this section are met and one of the following conditions is met:

(A) There was a binding contractual agreement that was executed on or before December 31, 1990 and obligates the hospital on or before December 31, 1990 for the lease or purchase of the item of equipment on or before December 31, 1990.

(B) There was a binding contractual agreement that was executed on or before December 31, 1990 and obligates the hospital on or before December 31, 1990 for financing the acquisition of the equipment, on or before December 31, 1990; or before December 31, 1990; the item of equipment costs at least \$100,000; and the item was specifically listed in an equipment purchase plan approved by the Board of Directors on or before December 31, 1990.

(iv) *Extension of deadline.* HCFA may extend the deadline in paragraph (c)(1)(i)(B) of this section, under which an asset must be put in use for patient care before October 1, 1994, to no later than September 30, 1996 for extraordinary circumstances beyond the hospital's control. Extraordinary circumstances include, but are not limited to, a construction strike or atypically severe weather that significantly delayed completion of a construction project. Normal construction delays do not constitute extraordinary circumstances.

(A) The hospital must submit its request for an extended deadline with documentation of the extraordinary circumstances by the later of January 1, 1993 or within 180 days of the extraordinary circumstance.

(B) The intermediary reviews the request and verifies the hospital's documentation, and forwards the request to HCFA within 60 days. Within 90 days, HCFA notifies the intermediary

of its decision and, if an extension is granted, of the revised deadline for putting the asset in use for patient care service.

(v) *Notification to intermediary.* The hospital must submit to its intermediary the binding agreement and supporting documents that relate to the obligated capital expenditure by the later of October 1, 1992 or within 90 days after the start of the hospital's first cost reporting period beginning on or after October 1, 1991.

(vii) *Determining old capital costs.*

(B) The intermediary advises the hospital of its determination within 12 months of the receipt of the hospital's notification under paragraph (c)(1)(v) of this section.

(2) *Lengthy certificate-of-need process.* (i) If a hospital does not meet the criteria under paragraph (c)(1)(i) or paragraph (c)(1)(ii) of this section, but meets all of the following criteria, the estimated cost for the project as of December 31, 1990 may be recognized as old capital costs:

(B) The hospital filed an initial application for a certificate of need on or before December 31, 1989 that includes a detailed description of the project and its estimated cost and had not received approval or disapproval on or before September 30, 1990. If the hospital received conditional approval on or before September 30, 1990, the hospital's intermediary assesses the nature of the conditions. The hospital will be considered to have received approval for the project as of September 30, 1990 if the intermediary determines that the hospital received sufficient approval for the project to proceed without significant delay.

In § 412.328, paragraph (a)(3) is added; paragraphs (b)(2), (b)(3), (c)(1), (f)(1)(i), and (f)(1)(iii) are revised; the introductory text of paragraph (f)(3) is republished; a new paragraph (f)(3)(iv) is added; paragraph (f)(4) is redesignated as paragraph (f)(5); and a new paragraph (f)(4) is added to read as follows:

§ 412.328 Determining and updating the hospital-specific rate.

(a) *Base-year cost reporting period.*

(3) *Other hospitals.* For other than a new hospital as defined in § 412.300(b), if a hospital does not have a 12-month cost reporting period ending on or

before December 31, 1990, the hospital-specific rate is based on the hospital's old capital costs (per discharge) in its first 12-month cost reporting period (or combination of cost reporting periods covering at least 12 months) ending after December 31, 1990.

(b) *Base-year costs per discharge.*

(2) *Discharges.* For the purpose of determining a hospital's base period capital costs per discharge a discharge, includes discharges as defined in § 412.4(a) and transfers as defined in § 412.4(b)(2), adjusted by the transfer adjustment factor that is determined under paragraph (b)(3) of this section.

(3) *Transfer adjustment factor.* (i) For base year cost reporting periods ending on or before December 31, 1990, HCFA uses the base year MEDPAR data received as of June 30, 1991 to develop an adjustment to discharges to account for transfers. HCFA divides the length of stay for each transfer case by the geometric mean length of stay for the DRG (but in no case using a number greater than 1.0) and assigns each nontransfer case a value of 1.0. To determine the transfer adjustment factor, HCFA adds together the adjusted discharges and divides the result by total discharges including transfers.

(ii) For base year cost reporting periods ending after December 31, 1990 but beginning before October 1, 1991, HCFA determines a transfer adjustment factor as described in paragraph (b)(3)(i) of this section for a hospital using the applicable base year MEDPAR data on file as of the December 31 or June 30 occurring at least 6 months after the close of the approved base year.

(iii) For base year cost reporting periods beginning on or after October 1, 1991, the intermediary determines the transfer adjustment factor in place of HCFA as described in paragraph (b)(3)(i) of this section based on the most recent billing data available as of the date of the final determination of the hospital specific rate.

(c) *Case-mix adjustment—(1)*

Determining transfer-adjusted case mix value. Step 1: For base year cost reporting periods ending on or before December 31, 1990, HCFA uses the base year MEDPAR data received as on June 30, 1991 to determine the hospital's transfer-adjusted case-mix value. For base year cost reporting periods ending after December 31, 1990 and beginning before October 1, 1991, HCFA determines a transfer-adjusted case-mix value for a hospital using the applicable base year MEDPAR data on file as of the December 31 or June 30 occurring at least 6 months after the close of the base

year. For base year cost reporting periods beginning on or after October 1, 1991, the intermediary determines the transfer-adjusted case-mix value based on the most recent billing data available as of the date of the final determination of the hospital-specific rate. HCFA or the intermediary, as appropriate, multiplies the DRG weight for each case by one of the following factors:

(f) *Redetermination of hospital-specific rate—*

(1) *General.* (i) Upon request by a hospital, the intermediary redetermines the hospital-specific rate to reflect an increase in old capital costs as determined in a cost reporting period subsequent to the base year. An increase in Medicare old capital cost per discharge that is related solely to a decline in utilization is not recognized as an increase in old capital costs for purposes of this section. New capital costs are excluded from the redetermination of the hospital-specific rate.

(iii) The hospital must request a redetermination in writing no later than the date the cost report must be filed with the hospital's intermediary for the first cost reporting period beginning on or after October 1, 1991 or the cost reporting period that will serve as the new base period whichever is later. The hospital's redetermination request must include the cost report for the new base period and an estimate of the revised hospital-specific rate indicating that the new rate exceeds the hospital's current hospital-specific rate.

(3) *Redetermined hospital-specific rate.* The intermediary redetermines the hospital-specific rate based on the old capital costs that are determined under paragraph (f)(2) of this section for the new base period. The intermediary—

(iv) If the intermediary determines, after audit, that the requested redetermination will result in a lower hospital-specific rate, it advises the hospital of its determination and provides the hospital the opportunity to withdraw its request within 60 days of the intermediary notice.

(4) *Withdrawing a request.* If the intermediary determines, after audit, that the revised hospital-specific rate is lower than the current hospital-specific rate, it advises the hospital of its determination and promptly notifies the hospital that it may withdraw its request within 60 days of the intermediary notice.

4. A new § 412.331 is added to read as follows:

§ 412.331 Determining hospital-specific rates in cases of hospital merger, consolidation, or dissolution.

(a) *Hospital merger or consolidation.* If, after the base year, two or more hospitals merge or consolidate into one hospital as provided for under § 413.134(k) of this chapter, the intermediary determines a revised hospital-specific rate applicable to the combined facility under § 412.328, which is effective beginning with the date of merger or consolidation. The following rules apply to the revised hospital-specific rate and payment determination:

(1) *Revised hospital-specific rate.* Using each hospital's base period data, the intermediary determines a combined average discharge weighted hospital-specific rate.

(2) *Payment determination.* The discharge-weighted hospital-specific rate determined by the intermediary is compared to the Federal rate to establish the appropriate payment methodology under § 412.336 and for payment purposes under §§ 412.340 or 412.344. The revised payment methodology is effective as of the date of merger or consolidation.

(3) *Old capital cost determination.* The capital-related costs related to the assets of each merged or consolidated hospital as of December 31, 1990 are recognized as old capital costs during the transition period. If the hospital is paid under the hold-harmless methodology after merger or consolidation, only that original base year old capital is eligible for hold-harmless payments.

(b) *Hospital dissolution.* If a hospital separates into two or more hospitals that are subject to capital payments under this subpart after the base year, the intermediary determines new hospital-specific rates for each separate hospital under the provisions of § 412.328 effective as of the date of the dissolution. The new hospital-specific rates are determined as follows:

(1) *Hospital-specific rate—(i) Adequate base year data.* The intermediary determines whether the base year capital-related cost data and necessary statistical records are adequate to reconstruct the cost and other data required under § 412.328 from the former hospital's financial records to determine the hospital-specific rates for each facility. If the data are adequate, the intermediary uses the former hospital's base period to determine the

hospital-specific rate for each separate hospital.

(ii) *Inadequate original base year data.* If the intermediary determines that the base period data for the former hospital is inadequate to establish separate hospital-specific rates, the intermediary establishes a new base period for each hospital. The new base period is each hospital's first 12-month or longer cost reporting periods covering at least 12 months) immediately following separation of the hospitals. The intermediary determines the hospital-specific rate for each hospital using the new base period under § 412.328.

(2) *Payment determinations.* The intermediary applies the payment methodology provisions of § 412.336. The revised payment determination is effective as of the date of the hospital's dissolution.

(3) *Old capital cost determination.* In determining the old capital costs for each hospital, the amount recognized as old capital is limited to the allowable capital-related costs attributable to assets that were in use for patient care as of December 31, 1990, and the hospitals are subject to all other transition period rules of this subpart.

5. Section 412.348(e)(2) is revised to read as follows:

§ 412.348 Exception payments during transition period.

(e) * * *

(2) A hospital must apply to its HCFA Regional Office by the later of October 1, 1992 or within 180 days of the extraordinary circumstance causing the unanticipated expenditures for a determination by the HCFA Administrator of whether the hospital is eligible for an additional payment based on the nature of the circumstances and the amount of financial loss documented by the hospital.

II. Part 413 is amended as follows:

A. The authority citation for part 413 continues to read as follows:

Authority: Sections 1102, 1814(b), 1815, 1833(a), (i), and (n), 1861(v), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395f(b), 1395g, 1395i(a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww); sec. 104(c) of Pub. L. 100-360 as amended by sec. 608(d)(3) of Pub. L. 100-485 (42 U.S.C. 1395ww (note)); and sec. 101(c) of Pub. L. 101-234 (42 U.S.C. 1395ww (note)).

Subpart A—Introduction and General Rules

B. Subpart A is amended as follows:

1. In § 413.1, paragraph (d)(2) introductory text and paragraph (d)(2)(i) are revised to read as follows:

§ 413.1 Introduction.

(d) *Payment for inpatient hospital services.*

(2) Payment to short-term general hospitals located in the 50 States and the District of Columbia for the operating costs of hospital inpatient services for cost reporting periods beginning on or after October 1, 1983, and for inpatient services for capital-related costs for cost reporting periods beginning on or after October 1, 1991 are determined prospectively on a per discharge basis under part 412 of this chapter except as follows:

(i) Payment for capital-related costs for cost reporting periods beginning before October 1, 1991, medical education, and kidney acquisition costs, and the costs of certain anesthesia services, is described in § 412.113 of this chapter.

2. In § 413.5, the introductory text of paragraph (c) is revised to read as follows:

§ 413.5 Cost reimbursement: General.

(c) As formulated herein, the principles give recognition to such factors as depreciation, interest, bad debts, educational costs, compensation of owners, and an allowance for a reasonable return on equity capital (in the case of certain proprietary providers). With respect to allowable costs some items of inclusion and exclusion are:

Subpart B—Accounting Records and Reports

C. Subpart B is amended as follows:

§ 413.24 [Amended]

In § 413.24(f)(3)(iii), the term "prospective payment system" is revised to read "prospective payment systems".

Subpart C—Limits on Cost Reimbursement

D. Subpart C is amended as follows:

In § 413.40, paragraph (a)(2)(i) introductory text is republished; paragraphs (a)(2)(i)(B), (c)(2), (f)(1)(i), and (g)(3)(iii) are revised; and a sentence is added at the end of paragraph (b)(1) to read as follows:

§ 413.40 Ceiling on rate of hospital cost increases.

(a) * * *

(2) *Applicability.* (i) This section is not applicable to—

(B) Hospitals that are paid under the prospective payment systems for inpatient hospital services in accordance with section 1886(d) and (g) of the Act and part 412 of this chapter.

(b) *Cost reporting periods subject to the rate of increase ceiling.* (1) * * * When the operational structure of a hospital or distinct unit changes (that is, a freestanding rehabilitation hospital becomes a distinct-part unit or vice versa) the base period would be the first full 12-month cost reporting period effective with the revised Medicare certification classification.

(c) * * *

(2) *Cost determined on a per case basis.* Costs subject to the ceiling as described in paragraph (c)(1) of this section are determined on a per discharge basis. For purposes of this subpart, a patient is considered discharged on the earliest of the following dates:

(i) The date the patient has exhausted Medicare Part A inpatient hospital benefits (including the election to use lifetime reserve days) during his or her spell of illness.

(ii) The date the patient is formally released as specified in § 412.4(a)(1) of this chapter;

(iii) The date the patient is transferred to another facility.

(iv) The date the patient dies.

(f) *Exemptions—(1)* * * *

(i) *New hospitals.* A new hospital is exempt from the rate-of-increase ceiling imposed under this section. The exemption begins when the hospital accepts its first patient and ends at the end of the first cost reporting period ending at least two years after the hospital accepts its first patient. The first 12-month cost reporting period beginning at least one year after the hospital accepts its first patient is the base year in accordance with paragraph (b) of this section. For purposes of this section, a new hospital is a provider of hospital inpatient services that—

(A) Has operated as the type of hospital for which HCFA granted it approval to participate in the Medicare program, under present or previous ownership (or both), for less than two full years; and

(B) Has not previously provided the type of hospital inpatient services for

which HCFA granted it approval to participate in the Medicare program.

(g) *Adjustments—*

(3) * * *

(iii) *Adjusting operating costs.*

Without a formal request from a hospital, HCFA may adjust the amount of operating costs determined under paragraph (c)(1) of this section to take into account certain adjustments. These adjustments include, but are not limited to, adjustments under paragraphs (g)(9)(ii) (A), (B), (C), (E), and (F) of this section.

Subpart E—Payments to Providers

E. Subpart E is amended as follows:

§ 413.64 [Amended]

In § 413.64, in paragraphs (h)(1)(i) and (h)(1)(ii), the term "prospective payment system" is revised to read "prospective payment systems".

Subpart F—Specific Categories of Costs

F. Subpart F is amended as follows:

Section 413.86 is amended by adding paragraph (h)(6) to read as follows:

§ 413.86 *Direct graduate medical education payments.*

(h) * * *

(6) On or after June 1, 1992, the United States Medical Licensing Examination may be substituted for the FMGEMS for purposes of the determination made under paragraphs (h)(1) and (h)(4) of this section. On or after July 1, 1993 only the results of steps I and II of the United States Medical Licensing Examination shall be accepted for purposes of making this determination.

Subpart G—Capital Related Costs

G. Subpart G is amended as follows:

§ 413.134 [Amended]

1. In § 413.134, in paragraph (f)(2)(iii)(D), the reference "§ 412.340(a)(2)" is revised to read "§ 412.344(a)(2)".

§ 413.157 [Amended]

2. In § 413.157, paragraph (c)(5) is removed.

(Catalog of Federal Domestic Assistance Program No. 93.733, Medicare—Hospital Insurance; No. 93.744, Medicare—Supplementary Medicare Insurance)

Dated: April 30, 1992.

William Tobey,

Acting Administrator, Health Care Financing Administration.

Approved: May 22, 1992.

Louis W. Sullivan,

Secretary.

[Editorial Note: The following addendum and appendixes will not appear in the Code of Federal Regulations.]

Addendum—Proposed Schedule of Standardized Amounts Effective with Discharges On or After October 1, 1992 and Update Factors and Target Rate Percentages Effective With Cost Reporting Periods Beginning On or After October 1, 1992

I. Summary and Background

In this addendum, we are making changes in the amounts and factors for determining prospective payment rates for Medicare inpatient operating costs and Medicare inpatient capital-related costs. We are also setting forth new target rate percentages for determining the rate-of-increase limits (target amounts) for hospitals and hospital units excluded from the prospective payment system.

For discharges occurring on or after October 1, 1992, except for sole community hospitals, Medicare-dependent small rural hospitals, hospitals located in Puerto Rico, and hospitals subject to the regional floor, each hospital's payment per discharge under the prospective payment system will be comprised of 100 percent of the Federal national rate.

For cost reporting periods beginning on or after April 1, 1990, sole community hospitals and, for cost reporting periods ending on or before March 31, 1993, Medicare-dependent small rural hospitals are paid based on whichever of the following rates yields the greatest aggregate payment: The Federal national rate (subject to the regional floor), the updated hospital-specific rate based on FY 1982 cost per discharge, or the updated hospital-specific rate based on FY 1987 cost per discharge. Hospitals in Puerto Rico are paid on the basis of a rate per discharge composed of 75 percent of a Puerto Rico rate and 25 percent of a national rate (section 1886(d)(9)(A) of the Act). Hospitals affected by the regional floor are paid on the basis of 85 percent of the Federal national rate and 15 percent of the Federal regional rate (section 1886(d)(1)(A)(iii) of the Act).

As discussed below in section II, we are making changes in the determination of the prospective payment rates for Medicare inpatient operating costs. The changes, to be applied prospectively,

will affect the calculation of the Federal rates. In section III we discuss changes we are making in the determination of the prospective payment rates for Medicare inpatient capital-related costs. Section IV sets forth our changes for determining the rate-of-increase limits for hospitals excluded from the prospective payment system. The tables to which we refer in the preamble to the proposed rule are presented at the end of this addendum in section V.

II. Proposed Changes to Prospective Payment Rates for Inpatient Operating Costs for FY 1993

The basic methodology for determining prospective payment rates for inpatient operating costs is set forth at § 412.63 for hospitals located outside of Puerto Rico. The basic methodology for determining the prospective payment rates for inpatient operating costs for hospitals located in Puerto Rico is set forth at §§ 412.210 and 412.212. Below, we discuss the manner in which we are changing some of the factors used for determining the prospective payment rates. The Federal and Puerto Rico rate changes, once issued as final, will be effective with discharges occurring on or after October 1, 1992. As required by section 1886(d)(4)(C) of the Act, we must adjust the DRG classifications and weighting factors for discharges in FY 1993.

In summary, the proposed standardized amounts set forth in Tables 1a, 1b, and 1c of section V of this addendum were—

- Updated by 2.75 percent for urban hospitals (that is, the market basket percentage increase of 4.3 percent minus 1.55 percent); and 3.75 percent for rural hospitals (that is, the market basket percentage increase of 4.3 percent minus 0.55 percent);

- Adjusted by removing the FY 1992 outlier offsets and applying the revised urban and rural outlier offsets;

- Adjusted to ensure budget neutrality as provided for in section 1886(d)(8)(D) of the Act by removing the FY 1992 budget neutrality factor and applying a revised factor; and

- Adjusted to ensure budget neutrality as provided for in sections 1886(d)(4)(C)(iii) and (d)(3)(E) of the Act by removing the FY 1992 budget neutrality adjustment factors and applying revised budget neutrality adjustment factors to the urban and rural standardized amounts.

A. Calculation of Adjusted Standardized Amounts

1. Standardization of Base-Year Costs or Target Amounts

Section 1886(d)(2)(A) of the Act required the establishment of base-year cost data containing allowable operating costs per discharge of inpatient hospital services for each hospital. The preamble to the September 1, 1983 interim final rule (48 FR 39763) contains a detailed explanation of how base-year cost data were established in the initial development of standardized amounts for the prospective payment system and how they are used in computing the Federal rates.

Section 1886(d)(9)(B)(i) of the Act required that Medicare target amounts be determined for each hospital located in Puerto Rico for its cost reporting period beginning in FY 1987. The September 1, 1987 final rule contains a detailed explanation of how the target amounts were determined and how they are used in computing the Puerto Rico rates (52 FR 33043, 33066).

The standardized amounts are based on per discharge averages of adjusted hospital costs from a base period or, for Puerto Rico, adjusted target amounts from a base period, updated and otherwise adjusted in accordance with the provisions of section 1886(d) of the Act. Sections 1886(d)(2)(C) and (d)(9)(B)(ii) of the Act required that the updated base-year per discharge costs and, for Puerto Rico, the updated target amounts, respectively, be standardized in order to remove the cost data the affects of certain sources of variation in cost among hospitals. These include case mix, differences in area wage levels, cost of living adjustments for Alaska and Hawaii, indirect medical education costs, and payments to hospitals serving a disproportionate share of low-income patients.

Since the standardized amounts have already been adjusted for differences in case mix, wages, cost-of-living, indirect medical education costs, and payments to hospitals serving a disproportionate share of low-income patients, no additional adjustments for these factors for FY 1993 were made. That is, the standardization adjustments reflected in the FY 1993 standardized amounts are the same as those reflected in the FY 1992 standardized amounts.

Sections 1886(d)(2)(H) and (d)(3)(E) of the Act require that, in making payments under the prospective payment system, the Secretary adjust the proportion of payments that are wage-related (as estimated by the Secretary from time to time). Beginning with October 1, 1990, when the market

basket was rebased, we have considered 71.40 percent of costs to be labor-related for purposes of the prospective payment system.

2. Computing Urban and Rural Averages Within Geographic Areas

Section 1886(d)(3) of the Act requires the Secretary to compute three average standardized amounts for discharges occurring in a fiscal year: One for hospitals located in rural areas; one for hospitals located in large urban areas; and one for hospitals located in other urban areas. In addition, under section 1886(d)(9)(B)(iii) of the Act, the average standardized amount per discharge must be determined for hospitals located in urban and rural areas in Puerto Rico. Hospitals in Puerto Rico are paid a blend of 75 percent of the applicable Puerto Rico standardized amount and 25 percent of a national standardized payment amount.

Section 1886(d)(2)(D) of the Act defines a "large urban area" as an urban area with a population of more than 1,000,000. In addition, section 4009(i) of Public Law 100-203 provides that a New England County Metropolitan Area (NECMA) with a population of more than 970,000 is classified as a large urban area. As required by section 1886(d)(2)(D) of the Act, population size is determined by the Secretary based on the latest population data published by the Bureau of the Census. Under that section, urban areas that do not meet the definition of a "large urban area" are referred to as "other urban areas."

Based on 1990 population estimates published by the Bureau of the Census, the current 49 large urban areas continue to meet the criteria to be defined as large urban areas for FY 1993. These areas are identified by an asterisk in Tables 4a and 4c. No additional areas have been identified. Therefore, we are making no change in these areas for purposes of this proposed rule. If new population estimates are published by the Bureau of Census by June 30, 1992, we will include any resulting changes in the list of large urban areas in the final rule.

Table 1a contains the three national standardized amounts that would continue to be applicable to most hospitals. Table 1b sets forth the 27 regional standardized amounts that would continue to be applicable for hospitals located in census areas subject to the regional floor. Under section 1886(d)(9)(A)(ii) of the Act, the national standardized payment amount applicable to hospitals in Puerto Rico consists of the discharge-weighted average of the national rural standardized amount, the national large

urban standardized amount, and the national other urban standardized amount (as set forth in Table 1a). The national average standardized amount for Puerto Rico is set forth in Table 1c. This table also includes the three standardized amounts that would be applicable to most hospitals in Puerto Rico.

The methodology for computing the national average standardized amounts is identical to the methodology for determining the regional amounts.

3. Updating the Average Standardized Amounts

In accordance with section 1886(d)(3)(A) of the Act, we are proposing to update the large urban, other urban, and rural average standardized amounts using the applicable percentage increases specified in section 1886(b)(3)(B)(i). Section 1886(b)(3)(B)(i)(VIII) of the Act (as added by sections 4002 (a) and (c) of Public Law 101-508) specifies the following update factors for the standardized amounts for FY 1993:

- The market basket percentage increase minus 1.55 percentage points (that is, 2.75 percent) for hospitals located in urban areas.
- The market basket percentage increase minus 0.55 percentage points (that is, 3.75 percent) for hospitals located in rural areas.

The percentage change in the market basket reflects the average change in the price of goods and services purchased by hospitals to furnish inpatient care. The most recent forecasted hospital market basket increase for FY 1993 is 4.3 percent.

Although the update factor for FY 1993 is set by law, we were required by section 1886(e)(3)(B) of the Act to report to Congress no later than March 1, 1992 on our initial recommendation of update factors for FY 1993 for both prospective payment hospitals and hospitals excluded from the prospective payment system. For general information purposes, we have included the report to Congress as Appendix C to this proposed rule. Our proposed recommendation on the update factors (which is required by sections 1886(e)(4)(A) and (e)(5)(A) of the Act), as well as our responses to ProPAC's recommendation concerning the update factor, is set forth as Appendix D to this proposed rule.

4. Other Adjustments to the Average Standardized Amounts

a. *Reclassified Hospitals—Budget Neutrality Adjustment.* Section 1886(d)(8)(B) of the Act provides that

certain rural hospitals are deemed urban effective with discharges occurring on or after October 1, 1988. In addition, section 1886(d)(10) of the Act provides for the reclassification of hospitals beginning in FY 1992 based on determinations by the Medicare Geographic Classification Review Board (MGCRB). Under section 1886(d)(10) of the Act, a hospital may be reclassified for purposes of the standardized amount or the wage index, or both. (See section I.A.1 of the preamble for a further explanation.)

Section 1886(d)(8)(D) of the Act specifies two budget neutrality objectives that must be met. First, the FY 1993 urban standardized amounts are to be adjusted so as to ensure that total aggregate payments under the prospective payment system after implementation of the provisions of sections 1886(d)(8)(B) and (C) and 1886(d)(10) of the Act are equal to the aggregate prospective payments that would have been made absent these provisions. Second, the rural standardized amounts are to be adjusted to ensure that aggregate payments to rural hospitals not affected by these provisions neither increase nor decrease as a result of implementation of these provisions. We note that some rural referral centers have been reclassified for purposes of the standardized amount. The budget neutrality adjustment for geographic reclassifications does not include the cost of paying the rural referral centers the other urban standardized amount since they are already paid on this basis. Rather, the budget neutrality adjustment includes only the difference between the payments to these hospitals after reclassification and payments as a rural referral center before reclassification (for example, higher disproportionate share payments or the difference between large urban and other urban rates, as applicable). Once the rural referral center triennial reviews are implemented beginning October 1, 1992 (see section V.B., above), it is likely that several of these hospitals will no longer be eligible for rural referral center status. At that point, it would be appropriate to include the cost of paying the hospitals the other urban standardized amount in the budget neutrality adjustment factor. Therefore, in calculating the final FY 1993 budget neutrality adjustment factor, we would identify those hospitals that are likely to lose their rural referral center status and determine the cost of paying them the urban standardized amount for the portion of FY 1993 that we estimate they would no longer

qualify as a rural referral center. We would include this cost in the budget neutrality adjustment factor. The following adjustment factors, necessary to achieve the requisite budget neutrality constraints, were applied to the proposed standardized amounts:

Urban	Rural
.987245	.999457

The adjustment factors are applied to the standardized amounts after removing the effects of the FY 1992 budget neutrality adjustment factors. We note that the proposed FY 1993 adjustments reflect wage index and standardized amount reclassifications approved by the MGCRB or the Administrator as of March 30, 1992. The effects of any additional reclassification changes resulting from appeals and review of the MGCRB's decisions for FY 1993 or from a hospital's request for the withdrawal of a reclassification request will be reflected in the final budget neutrality adjustment required under section 1886(d)(8)(D) of the Act.

b. *Recalibration of DRG Weights and Updated Wage Index—Budget Neutrality Adjustment.* Section 1886(d)(4)(C)(iii) of the Act specifies that beginning in FY 1991, the annual DRG reclassifications and recalibration of the relative weights must be made in a manner that ensures that aggregate payments to hospitals are not affected. As discussed in section II.C of the preamble, we normalized the recalibrated DRG weights by an adjustment factor so that the average case weight after recalibration is equal to the average case weight prior to recalibration. While this adjustment is intended to ensure that recalibration does not affect total payments to hospitals, our analysis indicates that the normalization adjustment does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals.

Section 1886(d)(3)(E) of the Act specifies that the hospital wage index must be updated based on new survey data no later than October 1, 1990 and on an annual basis beginning October 1, 1993. This provision also requires that any updates or adjustments to the wage index must be made in a manner that ensures that aggregate payments to hospitals are not affected by the change in the wage index.

To comply with the requirement of section 1886(d)(4)(C)(iii) of the Act that the DRG reclassification changes and recalibration of the relative weights be budget neutral and the requirement in

section 1886(d)(3)(E) of the Act that the updated wage index be implemented in a budget neutral manner, we compared aggregate payments using the FY 1992 relative weights and the wage index effective October 1, 1991 to aggregate payments using the proposed FY 1993 relative weights and wage index. The same methodology was used for the FY 1992 budget neutrality adjustment. (See the discussion in the August 30, 1991 final rule (56 FR 43246).) Based on this comparison, we computed a budget neutrality adjustment factor equal to 1.000007. We applied this budget neutrality adjustment factor to the standardized amounts after removing the effects of the FY 1992 budget neutrality adjustment.

In addition, we are proposing to continue to apply the same FY 1993 adjustment factor to the hospital-specific rates that are effective for cost reporting periods beginning on or after October 1, 1992, in order to ensure that we meet the statutory requirement that aggregate payments neither increase nor decrease as a result of the implementation of the DRG weights and updated wage index. (See the discussion in the September 4, 1990 final rule (55 FR 36073).)

c. *Retroactive Budget Neutrality Adjustment to Reflect FY 1992 Midyear Wage Index Corrections.* In the September 4, 1990 final rule (55 FR 36042), we set forth under § 412.63(l) (redesignated at § 412.63(p)) our policy for making mid-year corrections in the wage index and applying those corrections on a prospective basis effective with discharges occurring after the date the corrections are made. As described in that rule, when mid-year corrections are made under the provisions of § 412.63(l), the correction in the wage index value for the affected area is effective prospectively from the date the revision is made; however, both the corresponding prospective adjustment to the wage index values for all other wage areas (to reflect the effect of the corrected data on the national average hourly wage), and the budget neutrality adjustment to the standardized amounts required by section 1886(d)(3)(E) of the Act (to account for the effect on payments of the mid-year corrections), are not made until the beginning of the next fiscal year.

To account for the effect that mid-year corrections in the wage index for FY 1992 had on program payments for that year, we have computed a retroactive budget neutrality adjustment factor of .999586. This adjustment was computed by comparing FY 1992 aggregate

payments before the wage data corrections were made with aggregate payments after the revised wage index values were implemented. This adjustment has been applied to the FY 1993 standardized amounts after removing the effects of the FY 1992 budget neutrality adjustment for mid-year wage corrections.

d. *Outliers.* Section 1886(d)(5)(A) of the Act requires that, in addition to the basic prospective payment rates, payments must be made for discharges involving day outliers and may be made for cost outliers. Section 1886(d)(3)(B) of the Act requires that the urban and rural standardized amounts be separately reduced by the proportion of estimated total DRG payments attributable to estimated outlier payments for hospitals located in urban areas and those located in rural areas. Section 1886(d)(9)(B)(iv) of the Act requires that the urban and rural standardized amounts be reduced by the proportion of estimated total payments made to hospitals in Puerto Rico attributable to estimated outlier payments.

Consequently, instead of a uniform reduction factor applying equally to all the standardized amounts, there are two separate reduction factors, one applicable to the urban national and regional standardized amounts and the other applicable to the rural national and regional standardized amounts. Furthermore, sections 1886(d)(5)(A)(iv) and 1886(d)(9)(D)(i) of the Act direct that outlier payments in any year may not be less than 5 percent nor more than 6 percent of total payments projected to be made based on the prospective payment rates.

In the August 30, 1991 final rule, we set the outlier thresholds so as to result in estimated operating outlier payments equal to 5.1 percent of total operating prospective payments. We also set the same outlier thresholds and offsets for the Puerto Rico prospective payment standardized amounts as we had for hospitals located outside Puerto Rico. For FY 1992, the day outlier threshold is the geometric mean length of stay for each DRG plus the lesser of 32 days or 3.0 standard deviations. The cost outlier threshold is the greater of 2.0 times the prospective payment rate for the DRG or \$44,000 (\$40,100 for hospitals that have not yet entered the prospective payment system for inpatient capital-related costs). The outlier adjustments for FY 1992 that were effective for discharges on or after October 1, 1991 were .944047 for the urban rates, .979202 for the rural rates, and .949722 for the capital Federal rate.

As discussed in section V.A of the preamble, we are proposing to establish

outlier thresholds that would be applicable to both inpatient operating costs and inpatient capital-related costs. The proposed outlier adjustment factors applied to the standardized amounts and the capital Federal rate for FY 1993 are as follows:

Urban standardized amount	Rural standardized amount	Capital Federal rate
.944628	.978085	.9490

We would apply the proposed outlier adjustment factors after removing the effects of the FY 1992 outlier adjustment factors on the standardized amounts and the capital Federal rate.

We are proposing to continue to set the outlier thresholds so as to result in estimated outlier payments equal to 5.1 percent of total prospective payments. The model that we use to determine the outlier thresholds necessary to target our desired outlier payment percentage for FY 1993 uses the FY 1991 MEDPAR file and the most recent available information on hospital-specific payment parameters (such as the cost-to-charge ratios). This information is based on the December 31, 1991 update of the provider-specific file used in the PRICER program.

B. Adjustments for Area Wage Levels and Cost-of-Living

This section contains an explanation of the application of two types of adjustments to the adjusted standardized amounts that would be made by the intermediaries in determining the prospectus payment rates as described in section I.D of this addendum. For discussion purposes, it is necessary to present the adjusted standardized amounts divided into labor and nonlabor portions. Tables 1a, 1b, and 1c, as set forth in this addendum, contain the actual labor-related and nonlabor-related shares that will be used to calculate the prospectus payment rates for hospitals located in the 50 States, the District of Columbia, and Puerto Rico.

1. Adjustment for Area Wage Levels

Sections 1886(d)(2)(H) and 1886(d)(9)(C)(iv) of the Act require that an adjustment be made to the labor-related portion of the prospective payment rates to account for area differences in hospital wage levels. This adjustment is made by the intermediaries by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. In section

III of the preamble, we discuss certain revisions we are making to the wage index. This index is set forth in Tables 4a through 4c of this addendum.

2. Adjustment for Cost of Living in Alaska and Hawaii

Section 1886(d)(5)(H) of the Act authorizes an adjustment to take into account the unique circumstances of hospitals in Alaska and Hawaii. Higher labor-related costs for these two States are taken into account in the adjustment for area wages above. For FY 1993, the adjustment necessary for nonlabor-related costs for hospitals in Alaska and Hawaii would be made by the intermediaries by multiplying the nonlabor portion of the standardized amounts by the appropriate adjustment factor contained in the table below.

Table of cost-of-living adjustment factors, Alaska and Hawaii Hospitals

Alaska—All areas.....	1.25
Hawaii:	
Oahu	1.225
Kauai.....	1.175
Maui	1.20
Molokai	1.20
Lanai	1.20
Hawaii.....	1.15

(The above factors are based on data obtained from the U.S. Office of Personnel Management.)

C. DRG Weighting Factors

As discussed in section II of the preamble, we have developed a classification system for all hospital discharges, assigning them into DRGs, and have developed weighting factors for each DRG that are intended to reflect the resource utilization of cases in each DRG relative to Medicare cases in other DRGs.

Table 5 of section V of this addendum contains the weighting factors that we propose to use for discharges occurring in FY 1993. These factors have been recalibrated as explained in section II.C of the preamble.

D. Calculation of Prospective Payment Rates for FY 1993

General Formula for Calculation of Prospective Payment Rates for FY 1993

Prospective payment rate for all hospitals located outside Puerto Rico except sole community hospitals and, for cost reporting periods ending on or before March 31, 1993, Medicare-dependent, small rural hospitals = Federal rate.

Prospective payment rate for sole community hospitals and, for cost reporting periods ending on or before March 31, 1993, Medicare-dependent,

small rural hospitals = Whichever of the rates yields the greatest aggregate payment: 100 percent of the Federal rate, 100 percent of the FY 1982 hospital-specific rate, or 100 percent of the FY 1987 hospital-specific rate. Prospective payment rate for Puerto Rico = 75 percent of the Puerto Rico rate + 25 percent of a discharge-weighted average of the large urban, other urban, and rural national rates.

1. Federal Rate

For discharges occurring on or after October 1, 1992 and before October 1, 1993, except for sole community hospitals, Medicare-dependent, small rural hospitals (for cost reporting periods ending on or before March 31, 1993), hospitals located in Puerto Rico, and hospitals subject to the regional floor, the hospital's rate is comprised exclusively of the Federal national rate. Section 1886(d)(1)(A)(iii) of the Act provides that the Federal rate is comprised of 100 percent of the Federal national rate except for those hospitals located in census regions that have a regional rate that is higher than the national rate. The Federal rate for hospitals located in census regions that have a regional rate that is higher than the national rate equals 85 percent of the Federal national rate plus 15 percent of the Federal regional rate. For discharges occurring on or after October 1, 1992, rural hospitals in regions I, II, III, and IV and urban and large urban hospitals in regions I, IV, and VI are affected by the regional floor.

The Federal rates are determined as follows:

Step 1—Select the appropriate regional or national adjusted standardized amount considering the type of hospital and designation of the hospital as large urban, other urban, or rural (see Tables 1a and 1b, section V of this addendum).

Step 2—Multiply the labor-related portion of the standardized amount by the applicable wage index for the geographic area in which the hospital is located (see Tables 4a, 4b, and 4c, section V of this addendum).

Step 3—For examples in Alaska and Hawaii, multiply the nonlabor-related portion of the standardized amount by the appropriate cost-of-living adjustment factor.

Step 4—Add the amount from Step 2 and the nonlabor-related portion of the standardized amount (adjusted if appropriate under Step 3).

Step 5—Multiply the final amount from Step 4 by the weighting factor corresponding to the appropriate DRG (see Table 5, section V of this addendum).

2. Hospital-Specific Rate (Applicable Only to Sole Community Hospitals)

Section 1886(d)(5)(D)(i) of the Act provides that sole community hospitals are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal rate (subject to the regional floor), the updated hospital-specific rate based on FY 1982 cost per discharge, or the updated hospital-specific rate based on FY 1987 cost per discharge. Under section 1886(d)(5)(G) of the Act, Medicare-dependent small rural hospitals are eligible for special payment under the prospective payment system for cost reporting periods beginning on or after April 1, 1990 and ending on or before March 31, 1993 using the same formula applicable to sole community hospitals.

Hospital-specific rates have been determined for each of these hospitals based on both the FY 1982 cost per discharge and the FY 1987 cost per discharge. For a more detailed discussion of the calculation of the FY 1982 hospital-specific rate and the FY 1987 hospital-specific rate, we refer the reader to the September 1, 1983 interim final rule (48 FR 39772); the April 20, 1990 final rule with comment (55 FR 15150); and the September 4, 1990 final rule (55 FR 35994).

a. *Updating the FY 1982 and FY 1987 Hospital-Specific Rates for FY 1993 Cost Reporting Periods.* For cost reporting periods beginning on or after October 1, 1992, we are proposing to increase the hospital-specific rates by 4.3 percent (the hospital market basket percentage increase) for sole community hospitals located in all areas. The update, which is effective for cost reporting periods beginning in FY 1993, is not applicable to Medicare-dependent small rural hospitals since the provision ends with cost reporting periods ending after March 31, 1993. Section 1886(b)(3)(C)(ii) of the Act (as amended by section 4002(c)(2)(A)(ii) of Pub. L. 101-508) provides that the update factor applicable to the hospital-specific rates for sole community hospitals equals the update factor provided under section 1886(b)(3)(B)(ii) of the Act, which, for cost reporting periods beginning in FY 1993, is the market basket rate of increase.

b. *Calculation of Hospital-Specific Rate.* For sole community hospital cost reporting periods beginning on or after October 1, 1992 and before October 1, 1993, the applicable hospital-specific rate would be calculated by multiplying a hospital's hospital-specific rate for the preceding cost reporting period by the applicable update factor (that is, 4.3

percent). In addition, the hospital-specific rate would be adjusted by the budget neutrality adjustment factor (that is, 1.000007) as discussed in section II.A.4.b of this addendum. This resulting rate would be used in determining under which rate a sole community hospital is paid for its cost reporting period beginning on or after October 1, 1992, based on the formula set forth above.

3. General Formula for Calculation of Prospective Payment Rates for Hospitals Located in Puerto Rico Beginning On or After October 1, 1992 and before October 1, 1993

a. *Puerto Rico Rate.* The Puerto Rico prospective payment rate is determined as follows:

Step 1—Select the appropriate adjusted average standardized amount considering the large urban, other urban, or rural designation of the hospital (see Table 1c, section V of the addendum).

Step 2—Multiply the labor-related portion of the standardized amount by the appropriate wage index (see Tables 4a and 4b, section V of the addendum).

Step 3—Add the amount from Step 2 and the nonlabor-related portion of the standardized amount.

Step 4—Multiply the result in Step 3 by 75 percent.

Step 5—Multiply the amount from Step 3 by the weighing factor corresponding to the appropriate DRG weight (see Table 5, section V of the addendum).

b. *National Rate.* The national prospective payment rate is determined as follows:

Step 1—Multiply the labor-related portion of the national average standardized amount (see Table 1c, section V of the addendum) by the appropriate wage index.

Step 2—Add the amount from Step 1 and the nonlabor-related portion of the national average standardized amount.

Step 3—Multiply the result in Step 2 by 25 percent.

Step 4—Multiply the amount from Step 3 by the weighing factor corresponding to the appropriate DRG weight (see Table 5, section V of the addendum).

The sum of the Puerto Rico rate and the national rate computed above equals the prospective payment for a given discharge for a hospital located in Puerto Rico.

III. Proposed Changes to Payment Rates for Inpatient Capital-Related Costs for FY 1993

The prospective payment system for hospital inpatient capital-related costs was implemental for cost reporting periods beginning on or after October 1,

1991. Effective with that cost reporting period, hospital inpatient capital related costs are paid during a 10-year transition period extending through FY 2001 on the basis of an increasing proportion of the capital prospective payment system Federal rate and a decreasing proportion of the historical costs for capital as described below.

The basic methodology for determining Federal capital prospective rates is set forth at §§ 412.308-412.352 of the regulations. Below we discuss the manner in which we propose to change the factors used for determining the Federal rate and the hospital-specific rate. The rate changes would be effective for discharges occurring on or after October 1, 1992.

The FY 1992 standard Federal payment rate for capital-related costs under the prospective payment system was computed by updating the FY 1989 Medicare inpatient capital cost per case by an actuarial estimate of the increase in Medicare inpatient capital costs per discharge. The standard Federal rate is updated each year for increases in capital-related costs as provided in § 412.308(c)(1). Also, § 412.308(c)(2) provides that the Federal rate is adjusted annually by a factor equal to the estimated additional payments under the Federal rate for outlier cases, determined as a proportion of total capital payments under the Federal rate. For FY 1992 through FY 2001, § 412.308(c)(3) requires that the Federal rate be reduced by an adjustment factor equal to the estimated additional payments made for exceptions under § 412.348. Section 412.308(c)(4)(ii) requires that the Federal rate be adjusted so that estimated aggregate payments after any changes resulting from the annual DRG reclassification and the recalibration of DRG weights and in the geographic adjustment factor are budget neutral. For FY 1992 through FY 1995, § 412.352 requires that the

Federal rate is also adjusted by a budget neutrality factor, so that estimated aggregate payments for inpatient hospital capital costs will equal 90 percent of the estimated payments that would have been made for capital-related costs on a reasonable cost basis during the fiscal year.

The hospital-specific rate for each hospital was calculated by dividing the hospital's Medicare inpatient capital-related costs for a specified base year by its Medicare discharges (adjusted for transfers), and dividing the result by the hospital's case mix index (also adjusted for transfers). The resulting case-mix adjusted average cost per discharge was then updated to FY 1992 based on the national average increase in Medicare's inpatient capital cost per discharge and adjusted by the exceptions payment reduction factor and the budget neutrality adjustment factor to yield the FY 1992 hospital-specific rate. The hospital-specific rate is updated each year for inflation and for changes in the exceptions payment adjustment factor and the budget neutrality adjustment factor.

To determine the appropriate budget neutrality adjustment factors and the exceptions reduction factor, we developed a dynamic model of Medicare inpatient capital-related costs, that is, a model that projects changes in Medicare inpatient capital-related costs over time. The model and its application are more fully described in Appendix B.

In accordance with section 1886(d)(9)(A) of the Act, under the prospective payment system for inpatient operating costs, hospitals located in Puerto Rico are paid under a special payment formula. These hospitals are paid a blended rate that takes into account their geographical designation and is comprised of 75 percent of the applicable standardized amount specific to Puerto Rico hospitals and 25 percent of the applicable

national average standardized amount. Section 412.374 provides for the use of this blended payment system for payments to Puerto Rico hospitals in the prospective payment system for inpatient capital-related costs. Accordingly, for capital-related costs we compute a separate payment rate specific to Puerto Rico hospitals using the same methodology used to compute the national rate for capital-related costs. Hospitals in Puerto Rico are paid based on 75 percent of the Puerto Rico rate and 25 percent of the Federal rate.

A. Determination of Federal Inpatient Capital-Related Prospective Payment Rate Update

1. Standard Federal Rate Update

Section 412.308(c)(1)(i) provides that for FY 1993 through FY 1995, the standard Federal rate is updated on the basis of a lagged two-year moving average of actual increases in Medicare inpatient capital-related costs per discharge. The two-year moving average is based on the actual increase, adjusted for case-mix index change, in Medicare inpatient capital-related costs per case for the fiscal years three and four years before the fiscal year in question. For FY 1993, the increase is based on the increase in Medicare inpatient capital-related costs per case between FY 1988 and FY 1990. These are the most recent fiscal years for which cost report data are available. To determine the amount of the increase, we apportioned a hospital's costs and discharges to each fiscal year based on the number of months in the hospital's cost reporting period that occurred during the applicable fiscal year. Thus, an individual hospital may have more than one cost report included in the calculation.

We are proposing that the FY 1993 update for the Federal rate will be 3.76%. The following chart shows how this figure was computed:

CAPITAL PER CASE INCREASE FROM COST REPORT DATA

FY	Number of cost reports	Average capital cost per case	Percent increase	Observed case mix increase (percent)	Adjustment to case mix increase (percent)
1988	6356	\$485.75			
1989	6282	518.90	6.83	2.52	
1990	5155	547.23	5.46	0.85	1.22
FY	Adjusted case mix (percent)		Case mix adjusted increase		Average two year increase (percent)
1989		2.52		4.20	
1990		2.08		3.31	3.76

This computation was based on incomplete cost report data from FY

1990. As the above chart suggests, some hospital cost reports are not yet

included in the Hospital Cost Report Information System (HCRIS). We expect

data from those cost reports to become available on HCRIS before we publish the final rule. We will therefore recalculate the FY 1993 update factor on the basis of complete FY 1990 cost report data for the final rule. We note that the proposed FY 1993 update factor is 2.21 percentage points lower than the update factor of 5.97 percent which we projected from the capital acquisitions model for FY 1993.

2. Outlier Payment Adjustment Factor

Section 412.312(c) establishes a unified outlier methodology for inpatient operating and inpatient capital-related costs. A single set of thresholds is used to identify outlier cases for both inpatient operating and inpatient capital-related payments. Outlier payments are made only on the portion of the Federal rate that is used to calculate the hospital's inpatient capital-related payments (for example, 20 percent for cost reporting periods beginning in FY 1993 for hospitals paid under the fully prospective methodology). Section 412.308(c)(2) provides that the standard Federal rate for inpatient capital-related costs be reduced by an adjustment factor equal to the estimated additional payments under the Federal rate for outlier cases, determined as a proportion of inpatient capital-related payments under the Federal rate. The outlier thresholds are set so that 5.1 percent of estimated inpatient operating payments are paid as outlier payments. The inpatient capital-related outlier reduction factor is then set according to the estimated inpatient capital-related outlier payments that would be made if hospitals were all paid according to 100 percent of the Federal rate. It is appropriate, for purposes of calculating the outlier thresholds and the outlier reduction factor, to model all hospitals as if paid 100 percent of the Federal rate. This is because, as explained above, outlier payments are made only on the portion of the Federal rate that is included in the hospital's inpatient capital-related payments.

For FY 1992, we estimated that outlier payments would equal 5.03 percent of inpatient capital-related payments based on the Federal rate. Accordingly, we applied an outlier adjustment factor of .9497 to the Federal rate. Based on the proposed thresholds as set forth in section VI of the preamble, we estimate that outlier payments will equal 5.10 percent of inpatient capital-related payments based on the Federal rate in FY 1993. We are therefore proposing an outlier adjustment factor of 0.9490 to the Federal rate. The outlier reduction factors are not built permanently into

the rates; that is, they are not applied cumulatively in determining the Federal rate. Therefore the net change in the outlier adjustment to the Federal rate for FY 1993 is 0.9490/.9497 or 0.9993. Thus, the higher outlier payment percentage will reduce the FY 1993 Federal rate by .07 percent (1-0.9993) compared with the FY 1992 outlier adjustment.

3. Budget Neutrality Adjustment Factor for Changes in DRG Weight and the Geographic Adjustment Factor

Section 412.308(c)(4)(ii) requires that the Federal rate be adjusted so that estimated aggregate payments for the fiscal year based on any changes resulting from the annual reclassification and recalibration of the DRG weights and in the geographic adjustment factor equal estimated aggregate payments that would have been made on the basis of the Federal rate without such changes. We used the actuarial model described in Appendix B to estimate the aggregate payments that would have been made on the basis of the Federal rate without changes in the DRG classifications and weights and in the geographic adjustment factor. We also used the model to estimate aggregate payments that would have been made on the basis of the Federal rate as a result of those changes. We used these figures to compute the adjustment in DRG weights and in the geographic adjustment factor. For FY 1993, we are estimating that a budget neutrality factor of 0.9906 is necessary for this purpose. We note that this factor accounts only for changes due to DRG classification changes and recalibration and in the geographic adjustment factor. It does not account for changes in payments due to changes in the disproportionate share and indirect medical education adjustment factors. It incorporates the effects on the geographic adjustment factor of FY 1993 geographic reclassification decisions made by the MGCRB compared to FY 1992 decisions.

4. Budget Neutrality Factor to Assure Aggregate Payments Equal 90 Percent of Reasonable Cost Payments

As amended by section 4001(b) of Public Law 101-508, section 1886(g)(1)(A) of the Act requires that aggregate payments made each year in FY 1992 through FY 1995 for hospital inpatient services be reduced in a manner that results in savings equivalent to 10 percent of what HCFA estimates would have been payable on a reasonable cost basis for inpatient capital-related costs in that year. The Conference Committee report accompanying Public Law 101-508

indicated that, prior to the fiscal year, the Secretary may estimate the budget neutrality adjustment based on the best available information (H.R. Conf. Rep. No. 964, 101st Cong., 2nd Sess. 691 (1990)). In keeping with the legislation, no retroactive increase or decrease is made if aggregate payments are greater than or less than 90 percent of actual Medicare inpatient capital-related costs for that year.

Section 412.352 of the regulations provides that HCFA determines an adjustment to the hospital-specific rate and the Federal rate proportionately, so that the estimated payments for capital in each year from FY 1992 through FY 1995 will equal 90 percent of what would have been payable that year on a reasonable cost basis. The effect of this provision is that the savings required under section 1886(g)(1)(A) of the Act are realized entirely through a reduction in payment for capital costs in FY 1992 through FY 1995.

For FY 1992, we determined that a budget neutrality factor of 0.9602 was required, so that aggregate payments for inpatient capital-related costs would equal 90 percent of what would have been payable on a reasonable cost basis in that year. As we explain in Appendix B, there was practically no capital data available for use in setting the capital budget neutrality factor for FY 1992. We now have available some data that can be used directly in the determination of the budget neutrality factor. For FY 1993, we are using an actuarial model that integrates the available data with results from the FY 1992 capital acquisition model for items for which data are still missing. On the basis of the integrated model, we now estimate that capital-PPS payments for FY 1992 will equal approximately 92.09 percent of what we estimate would have been payable on a reasonable cost basis for inpatient capital-related costs in FY 1992. In other words, we now estimate that capital-PPS payments for FY 1992 will exceed the 90 percent budget neutrality target by approximately 2.09 percentage points.

We believe that there are at least two reasons for the difference between our estimate in the final rule for FY 1992 and the estimate based on the most recent data. One reason is that more hospitals appear to be qualifying as high cost hospitals receiving payment under the hold-harmless methodology than we originally estimated. In the preamble to the final rule, we estimated that 29 percent of hospitals subject to the capital-PPS system would qualify for hold-harmless payments. On the basis of the data now available, our actuarial

model estimates that about 36 percent of hospitals are qualifying for hold-harmless payments in FY 1992. Another reason is that exceptions payments appear to be higher than we previously estimated. On the basis of the data now available, the actuarial model estimates that more hospitals will receive exceptions payments, and that they will receive higher payments, than we anticipated on the basis of our original model simulations for FY 1992. Since the budget neutrality and exceptions reduction factors interact, the revised estimate of exceptions payments for FY 1992 has an effect on the determination of the budget neutrality factor.

While we do not retroactively adjust budget neutrality factors for previous years to account for revisions in our estimates, we do employ the information obtained through our monitoring efforts to refine the budget neutrality adjustment for subsequent years. Thus, we have used the most recently available data to establish the proposed budget neutrality adjustment for FY 1993. For FY 1993, we are proposing a budget neutrality factor of 0.9564 to realize the required expenditure level. The budget neutrality factors are not built permanently into the rates; that is, the factors are not applied cumulatively in determining the Federal rate. The net adjustment to the FY 1993 Federal rate would therefore be .9564/.9602 or .9960. We will continue to integrate newly available data with the results from the model used in FY 1992, and we will recalculate the budget neutrality factor on the basis of all the data available at the time we publish the final rule.

5. Exceptions Payment Adjustment Factor

Section 412.308(c)(3) requires that the standard Federal rate for inpatient capital-related costs be reduced by an adjustment factor equal to the estimated additional payments for exceptions under § 412.348 determined as a

proportion of total payments under the hospital-specific rate and Federal rate. The model developed for determining the budget neutrality adjustment factor is also used to estimate payments under the exceptions payment process and to determine the exceptions payment adjustment factor.

For FY 1992, we estimated that exceptions payments would equal 1.87 percent of aggregate payments based on the Federal rate and the hospital-specific rate. Therefore, we applied an exceptions reduction factor of .9813 (1-0.0187) in determining the Federal rate. For FY 1993, we estimate that exceptions payments will equal 3.9 percent of aggregate payments based on the Federal rate and the hospital-specific rate. Therefore, we propose to apply an exceptions reduction factor of 0.9610 to determine the FY 1993 Federal rate. The exceptions reductions factors are not built permanently into the rates; that is, the factors are not applied cumulatively in determining the Federal rate. The net adjustment to the FY 1993 Federal rate is therefore .9610/.9813, or .9793.

6. Standard Federal Rate for FY 1993

For FY 1992, the Federal rate was \$415.59. With the changes we are proposing to the factors used to establish the Federal rate, we are proposing that the FY 1993 Federal rate will be \$416.36. The changes are calculated as follows:

- The FY 1993 update factor would be 1.0376.
- The FY 1993 outlier adjustment factor would be 0.9490.
- The FY 1993 budget neutrality adjustment factor that is applied to the standard Federal payment rate for changes in the DRG relative weights and in the geographic adjustment factor would be 0.9906.
- The FY 1993 budget neutrality adjustment factor that is applied to the standard Federal payment rate and the

hospital-specific rate to assure that aggregate payments equal 90 percent of payments that would have been made on a reasonable cost basis would be 0.9564.

• The FY 1993 exceptions payments adjustment factor would be 0.9610.

Since the Federal rate has already been adjusted for differences in case mix, wages, cost-of-living, indirect medical education costs, and payments to hospitals serving a disproportionate share of low-income patients, we propose to make no additional adjustments in the standard Federal rate for these factors other than the budget neutrality factors for changes in the DRG relative weights and the geographic adjustment factor.

We are providing below a comparison of the proposed rate calculation that accounts for changes in the Federal rate from FY 1992. At each step, dollar amounts are shown to illustrate the cumulative effect on the Federal rate of each adjustment factor, and the difference in the effect of each adjustment factor between the final FY 1992 rate and the proposed rate for FY 1993. The cumulative percent change column shows the difference, to that point in the table, between the rate in FY 1992 and the proposed rate for FY 1993.

The 1993 update increases the Federal rate 3.76 percent compared to the rate in FY 1992 while the geographic and DRG budget neutrality factor decrease the Federal rate by 0.94 percent. The exceptions reduction factor decreases the proposed Federal rate by 2.07 percent compared to the exceptions reduction for FY 1992. The budget neutrality adjustment factor reduces the proposed FY 1993 rate by 0.40 percent compared to the budget neutrality reduction in FY 1992. The combined effect of all the proposed changes is to increase the proposed Federal rate by 0.19 percent compared to the Federal rate for FY 1992.

COMPARISON OF FEDERAL RATE CALCULATION FROM FY 92 FINAL RULE TO FY 93 PROPOSED RULE

	Cost per discharge	Percent change from FY 1992 rate	Cumulative percent change from FY 1992 rate
FY 89 cost per discharge.....	\$527.22		
FY 89 cost per discharge updated to 92, adjusted for transfers and payment parameters.....	464.42		
93 update factor:			
FY 92.....	464.42		
FY 93: 1.0376.....	481.88	+3.76	+3.76
GAF/DRG budget neutrality factor:			
FY 92: 1.0000.....	464.42		
FY 93: 0.9906.....	477.35	-0.94	+2.78
Outlier reduction factor:			
FY 92: 0.9497.....	441.06		
FY 93: 0.9490.....	453.01	-0.07	+2.71

COMPARISON OF FEDERAL RATE CALCULATION FROM FY 92 FINAL RULE TO FY 93 PROPOSED RULE—Continued

	Cost per discharge	Percent change from FY 1992 rate	Cumulative percent change from FY 1992 rate
Exceptions reduction factor:			
FY 92: 0.9813	432.81		
FY 93: 0.9610	435.34	-2.07	+0.58
Budget neutrality reduction factor:			
FY 92: 0.9602	415.59		
FY 93: 0.9564	416.36	-0.40	+0.19
Net change:			
FY 92 rate	415.59		
FY 93 rate	416.36	+0.19	

We have refined our proposed budget neutrality and exceptions reduction factors for FY 1993 on the basis of the most recent data at our disposal. We have not retroactively adjusted the Federal rate for FY 1992 in determining the proposed rate for FY 1993. We are providing a chart that demonstrates how our proposed FY 1993 Federal rate differs from the projection we made when we published the final rule for the capital prospective payment system on August 30, 1991. At that time, we projected that the Federal rate for FY 1993 would be \$430.17. This projection was based on an anticipated update factor of 1.0579, and expected exceptions reduction and budget neutrality factors of 0.9605 and 0.9582, respectively. Our proposed FY 1993 Federal rate of \$416.36 is 3.21 percent

lower than our August 1991 projection. As the chart shows, there are two major reasons for the difference between the projection and our current proposal. First, our projection did not include the budget neutrality factor for changes in DRG weights and in the geographic adjustment factor. Application of this factor in determining the proposed rate for FY 1993 accounts for a 0.94 percent reduction. The other reason is that the update factor used to compute the proposed rate is 2.21 percentage points lower than the update factor we used in our projection. This accounts for a 2.09 percent reduction in the proposed rate for FY 1993 compared with the projected rate. As we discuss in section III.A.1 of this Addendum, the update factor for FY 1993 is the average of the actual increases in Medicare inpatient capital-

related costs per case between FY 1988 and FY 1990. The average capital cost per case for FY 1990 is lower than we originally anticipated. However, the FY 1990 average we have employed in developing the proposed FY 1993 Federal rate is based upon as yet incomplete cost report data for FY 1990. We expect to have complete FY 1990 cost report data available before we publish the final rule. We will therefore recalculate the FY 1993 update factor on the basis of complete FY 1990 data for the final rule. Also, we note that although the proposed Federal rate is only .19 percent higher than the FY 1992 rate, total payments per case under the capital prospective payment system are projected to increase 7.57 percent.

COMPARISON OF FEDERAL RATE CALCULATION AUGUST 1991 PROJECTION AND FY 1993 RATE

	Cost per discharge	Percent change from projected rate	Cumulative percent change from projected rate
FY 89 cost per discharge	\$527.22		
FY 89 cost per discharge updated to FY 92, adjusted for transfers and payment parameters	464.42		
Update factor:			
Projection: 1.0597	492.15		
Proposed FY 1993: 1.0376	481.88	-2.09	-2.09
GAF/DRG budget neutrality adjustment factor:			
Projection: ---	492.15		
Proposed FY 1993: 0.9906	477.35	-0.94	-3.01
Outlier adjustment factor:			
Projection: 0.9497	467.39		
Proposed FY 1993: 0.9490	453.01	-0.07	-3.08
Exceptions reduction factor:			
Projection: 0.9605	448.93		
Proposed FY 1993: 0.9610	435.34	+0.05	-3.03
Budget neutrality factor:			
Projection: 0.9582	430.17		
Proposed FY 1993: 0.9564	416.36	-0.19	-3.21
Net change:			
Projected Federal Rate	430.17		
FY 1993 Proposed Federal Rate	416.36	-3.21	

7. Special Rate for Puerto Rico Hospitals

For FY 1992, the special rate for Puerto Rico hospitals was \$319.68. With the changes we are proposing to the factors used to determine the rate, we

are proposing that the FY 1993 special rate for Puerto Rico will be \$320.27.

B. Determination of Hospital-Specific Rate Update

Section 412.328(e) of the regulations provides that the hospital-specific rate each year be determined by adjusting

the FY 1992 hospital-specific rate by the following factors:

1. Hospital-Specific Rate Update Factor

The hospital specific rate is updated in accordance with the update factor for the standard Federal rate determined under § 412.308(c)(1). For FY 1993, we are proposing that the hospital-specific rate be updated by a factor of 1.0376.

2. Exceptions Payment Adjustment Factor

For FY 1992 through FY 2001, the updated hospital-specific rate is reduced by an adjustment factor equal to the estimated additional payments for capital-related costs for exceptions under § 412.348, determined as a proportion of the total amount of payments under the hospital-specific rate and the Federal rate. For FY 1993, we estimate that exceptions payments will be 3.9 percent of aggregate payments based on the Federal rate and the hospital-specific rate. We therefore

propose that the updated hospital-specific rate be reduced by a factor of 0.9813. The exceptions reductions factors are not built permanently into the rates; that is, the factors are not applied cumulatively in determining the hospital-specific rate. The net adjustment to the FY 1993 hospital-specific rate is therefore .9610/.9813 or .9793.

3. Budget Neutrality Adjustment Factor

For FY 1992 through FY 1995, the updated hospital specific rate is adjusted by a budget neutrality adjustment factor determined under § 412.352 of the regulations so that estimated aggregate payments under the capital prospective payment system will equal 90 percent of what would have been payable on a reasonable cost basis. (The budget neutrality adjustment for changes in the DRG relative weights and in the geographic adjustment factor is not applied to the hospital-specific

rate.) For FY 1993, we are proposing a budget neutrality factor of 0.9564. The budget neutrality factor is not built permanently into the rates; that is, the factor is not applied cumulatively in determining the hospital-specific rate. The net adjustment to the FY 1993 hospital-specific rate is therefore .9564/.9602 or .9960.

4. Net change to Hospital-Specific Rate

We are providing a chart below to show the proposed net change to the hospital-specific rate. The chart shows the factors for FY 1992 and FY 1993 and the net adjustment for each factor. It also shows that the proposed cumulative net adjustment from FY 1992 to FY 1993 is 1.0121, which represents an increase of 1.21 percent to the hospital-specific rate. The proposed FY 1993 hospital-specific rate for each hospital can be determined by multiplying the FY 1992 hospital-specific rate by the cumulative net adjustment of 1.0121.

PROPOSED FY 1993 UPDATE AND ADJUSTMENTS TO HOSPITAL-SPECIFIC RATES

		Net adjustment	Percent change
Update factor:			
FY 92.....			
FY 93.....	1.0376	1.0376	+3.76
Exceptions payment adjustment factor:			
FY 92.....	0.9813		
FY 93.....	0.9610	0.9793	-2.07
Budget neutrality factor:			
FY 92.....	0.9602		
FY 93.....	0.9564	0.9960	-0.40
Cumulative adjustments:			
FY 92.....	0.9422		
FY 93.....	0.9537	1.0121	+1.21

C. Calculation of Inpatient Capital-Related Prospective Payments for FY 1993

During the capital prospective payment system transition period, a hospital is paid for the inpatient capital-related costs under one of two alternative payment methodologies: The fully prospective payment methodology or the hold-harmless methodology. The payment methodology applicable to a particular hospital is determined when a hospital comes under the prospective payment system for capital-related costs by comparing its hospital-specific rate to the Federal rate applicable to the hospital's first cost reporting period under the prospective payment system. The applicable Federal rate is determined by adjusting:

- For outliers by dividing the standard Federal rate by the outlier reduction factor for that fiscal year; and,

- For the payment adjustment factors applicable to the hospital (that is, the hospital's geographic adjustment factor, the disproportionate share adjustment factor, and the indirect medical education adjustment factor, where appropriate). If the hospital-specific rate is above the applicable Federal rate, the hospital is paid under the hold-harmless methodology. If the hospital-specific rate is below the applicable Federal rate, the hospital is paid under the fully prospective methodology.

For purposes of calculating payments for each discharge under both the hold-harmless payment methodology and the fully prospective payment methodology, the standard Federal rate is adjusted as follows:

$$(\text{Standard Federal Rate}) \times (\text{DRG weight}) \times (\text{Geographic Adjustment Factor}) \times (\text{Large Urban Add-on, if applicable}) \times (\text{for hospitals located in Alaska and Hawaii, COLA}$$

$$\text{adjustment}) \times (1 + \text{Disproportionate Share Adjustment Factor} + \text{Indirect Medical Education Adjustment Factor, if applicable}).$$

The result is termed the adjusted Federal rate.

Payments under the hold-harmless methodology are determined under one of two formulas. A hold-harmless hospital is paid the higher of:

- 100 percent of the adjusted Federal rate for each discharge; or
- An old capital payment equal to 85 percent (100 percent for sole community hospitals) of the hospital's allowable Medicare inpatient old capital costs per discharge for the cost reporting period plus a new capital payment based on a percentage of the adjusted Federal rate for each discharge. The percentage of the adjusted Federal rate equals the ratio of the hospital's allowable Medicare new capital costs to its total

Medicare inpatient capital-related costs in the cost reporting period.

Once a hospital receives payment based on 100 percent of the adjusted Federal rate in a cost-reporting period beginning on or after October 1, 1993 (or the first cost reporting period after obligated capital that is recognized as old capital under § 412.302(c) is put in use for patient care, if later), the hospital continues to receive capital prospective payment system payments on that basis throughout the transition period.

Payment for each discharge under the fully prospective methodology is the sum of:

- The hospital-specific rate multiplied by the DRG relative weight for the discharge and by the applicable hospital-specific transition blend percentage for the cost reporting period; and
- The adjusted Federal rate multiplied by the Federal transition blend percentage.

The blend percentages for cost reporting periods beginning in FY 1993 are 20 percent of the adjusted Federal rate and 80 percent of the hospital-specific rate.

Hospitals may also receive outlier payments for those cases that qualify under the thresholds established for each fiscal year. Section 412.312(c) provides for a single set of thresholds to identify outlier cases for both inpatient operating and inpatient capital-related payments. Outlier payments are made only on that portion of the Federal rate that is used to calculate the hospital's inpatient capital-related payments. For fully prospective hospitals, that will be 20 percent of the Federal rate for discharges occurring in cost reporting periods beginning during FY 1993. Thus, a fully prospective hospital will receive 20 percent of the capital-related outlier payment calculated for the case for discharges occurring in cost reporting periods beginning in FY 1993. For hold-harmless hospitals paid 85 percent of their reasonable costs for old inpatient capital, the portion of the Federal rate that is included in the hospital's outlier payments is based on the hospital's ratio of Medicare inpatient costs for new capital to total Medicare inpatient capital costs. For hold-harmless hospitals that are paid 100 percent of the Federal rate, 100 percent of the Federal rate is included in the hospital's outlier payments.

The proposed rules to establish outlier thresholds for FY 1993 are published in section V.A of the preamble to this proposed rule. For FY 1993, we are proposing that a case qualifies as a cost outlier if the cost for the case (after standardization for the indirect teaching

adjustment and disproportionate share adjustment) is greater than the larger of 2.0 times the prospective payment rate for the case or \$34,500. We are also proposing that a case qualifies as a day outlier for FY 1993 if the length of stay is greater than the geometric mean length of stay for the DRG plus the lesser of three standard deviations of the length of stay or 23 days.

During the capital prospective payment system transition period, any hospital may also receive an additional payment under an exceptions process if its total inpatient capital-related payments are less than a minimum percentage of its allowable Medicare inpatient capital-related costs. The minimum payment level is established by class of hospital under § 412.348. The minimum payment levels for portions of cost reporting periods occurring in FY 1993 are:

- Sole community hospitals (located in either an urban or rural area), 90 percent;
- Urban hospitals with at least 100 beds and a disproportionate share patient percentage of at least 20.2 percent and urban hospitals with at least 100 beds that qualify for disproportionate share payments under § 412.106(c)(2), 80 percent; and,
- All other hospitals, 70 percent.

Under § 412.348(d), the amount of the exceptions payment is determined by comparing the cumulative payments made to the hospital under the capital prospective payment system to the cumulative minimum payment levels applicable to the hospital for each cost reporting period subject to that system. Any amount by which the hospital's cumulative payments exceed its cumulative minimum payment is deducted from the additional payment that would otherwise be payable for a cost reporting period.

New hospitals are exempted from the capital prospective payment system for their first two years of operation and are paid 85 percent of their reasonable costs during that period. As discussed in section VI.A. of the preamble, we are proposing to clarify that a new hospital's old capital costs are its allowable costs for capital assets that were put in use for patient care on or before the later of December 31, 1990 or the last day of the hospital's base year cost reporting period, and are subject to the rules pertaining to old capital and obligated capital as of the applicable date. Effective with the third year of operation, we will pay the hospital under either the fully prospective methodology, using the appropriate transition blend in that Federal fiscal year, or the hold-harmless methodology.

If the hold-harmless methodology is applicable, the hold-harmless payment for assets in use during the base period would extend for 8 years, even though the hold-harmless payments may extend beyond the normal transition period.

IV. Proposed Target Rate Percentages for Hospitals and Hospital Units Excluded From the Prospective Payment System

The inpatient operating costs of hospitals and hospital units excluded from the prospective payment system are subject to rate-of-increase limits established under the authority of section 1886(b) of the Act, which is implemented in § 413.40 of the regulations. Under these limits, an annual target amount (expressed in terms of the inpatient operating cost per discharge) is set for each hospital, based on the hospital's own historical cost experience, trended forward by the applicable update factors. This target amount is applied as a ceiling on the allowable costs per discharge for the hospital's next cost reporting period.

Effective with cost reporting periods beginning on or after October 1, 1991, a hospital that has inpatient operating costs per discharge in excess of its target amount will be paid its target amount plus 50 percent of its costs in excess of the target amount. Total payments may not exceed 110 percent of the target amount. However, a hospital that has inpatient operating costs less than its target amount will be paid its costs plus the lower of—

- Fifty percent of the difference between the inpatient operating cost per discharge and the target amount; or
- Five percent of the target amount.

Each hospital's target amount is adjusted annually, before the beginning of its cost reporting period, by an applicable target rate percentage. For cost reporting periods beginning on or after October 1, 1992 and before October 1, 1993, section 1886(b)(3)(B)(ii) of the Act provides that the applicable percentage increase is the market basket percentage increase. In order to determine a hospital's target amount for its cost reporting period beginning in FY 1993, the hospital's target amount for its reporting period that began in FY 1992 is increased by the market basket percentage increase for FY 1993. The most recent forecasted market basket increase for FY 1993 for hospitals and units excluded from the prospective payment system is 4.5 percent. Therefore, the applicable percentage increase is also 4.5 percent.

V. Tables

This section contains the tables referred to throughout the preamble to this proposed rule and in this addendum. For purposes of this final rule, and to avoid confusion, we have retained the designations of Tables 1a, 1b, 1c, 3c, 4a, 4b, and 5 that were first used in the September 1, 1983 initial prospective payment final rule (48 FR 39844). Tables 1a, 1b, 1c, 1d, 3C, 4a, 4b, 4c, 5, 6a, 6b, 6c, 6d, 6e, 6f, 6g, 6h, 7A, 7B, 8a, 8b, and 9 are presented below. The tables presented below are as follows:

Table 1a—National Adjusted Operating Standardized Amounts, Labor/Nonlabor
Table 1b—Regional Adjusted Operating Standardized Amounts, Labor/Nonlabor
Table 1c—Adjusted Operating Standardized Amounts for Puerto Rico, Labor/Nonlabor

Table 1d—Capital Standard Federal Payment Rate

Table 3C—Hospital Case Mix Indexes for Discharges Occurring in Federal Fiscal Year 1990

Table 4a—Wage Index and Capital Geographic Adjustment Factor (GAF) for Urban Areas

Table 4b—Wage Index and Capital Geographic Adjustment Factor (GAF) for Rural Areas

Table 4c—Wage Index and Capital Geographic Adjustment Factor (GAF) for Hospitals that are Reclassified

Table 5—List of Diagnosis Related Groups (DRGs), Relative Weighting Factors, Geometric Mean Length of Stay, and Length of Stay Outlier Cutoff Points Used in the Prospective Payment System

Table 6a—New Diagnosis Codes

Table 6b—New Procedure Codes

Table 6c—Invalid Diagnosis Codes

Table 6d—Invalid Procedure Codes

Table 6e—Revised Diagnosis Code Titles

Table 6f—Revised Procedure Code Titles

Table 6g—Additions to the CC Exclusions List

Table 6h—Deletions to the CC Exclusions List

Table 7A—Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 91 MEDPAR Update 12/91 GROUPE V9.0

Table 7B—Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 91 MEDPAR Update 12/91 GROUPE V10.0

Table 8a—Statewide Average Operating Cost-to-Charge Ratios for Urban and Rural Hospitals (Case Weighted)

Table 8b—Statewide Average Capital Cost-to-Charge Ratios for Urban and Rural Hospitals (Case Weighted)

Table 9—1991 Transfer Adjusted Case Mix Index and Transfer Adjustment to Discharges for Capital Hospital-Specific Rate Redeterminations

TABLE 1A.—NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR

Large urban		Other urban		Rural	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
2594.12	1068.75	2553.05	1051.84	2626.19	846.11

TABLE 1B.—REGIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR

	Large urban		Other urban		Rural	
	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
1. New England (CT, ME, MA, NH, RI, VT)	2724.24	1116.00	2681.11	1098.33	2911.62	1004.15
2. Middle Atlantic (PA, NJ, NY)	2447.49	1057.28	2408.74	1040.54	2788.46	949.28
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	2612.60	975.75	2571.24	960.30	2665.64	823.15
4. East North Central (IL, IN, MI, OH, WI)	2755.66	1154.48	2712.04	1136.20	2699.32	914.86
5. East South Central (AL, KY, MS, TN)	2507.38	883.52	2467.68	869.54	2641.93	767.60
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	2613.35	1051.92	2571.98	1035.27	2567.76	820.06
7. West South Central (AR, LA, OK, TX)	2598.31	969.14	257.17	953.80	2462.59	754.17
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	2506.45	1038.08	2466.77	1021.65	2490.33	867.40
9. Pacific (AK, CA, HI, OR, WA)	2438.08	1,185.79	2399.49	1167.02	2422.06	977.17

TABLE 1C.—ADJUSTED OPERATING STANDARDIZED AMOUNTS FOR PUERTO RICO LABOR NONLABOR

	Large urban		Other urban		Rural	
	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
Puerto Rico	2333.14	485.24	2296.20	477.56	1790.07	385.90
National	2587.30	1006.27				

TABLE 1D.—CAPITAL STANDARD FEDERAL PAYMENT RATE

	Rate
National	416.36
Puerto Rico	320.27

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
010001	01.2775	010065	01.2063	010130	01.1185	030012	01.2290	030086	01.1894
010004	00.9132	010066	00.9436	010131	01.2511	030013	01.2429	030087	01.6015
010005	01.1192	010068	01.2064	010134	00.8435	030016	01.4006	030088	01.2872
010006	01.3435	010069	01.1523	010136	00.9504	030017	01.2747	030089	01.2291
010007	01.1001	010072	01.1109	010137	01.2242	030018	01.3580	030091	00.8278
010008	01.0040	010073	00.8996	010138	00.9187	030019	01.5921	030092	01.4527
010009	01.0231	010078	01.1838	010139	01.5177	030022	01.3881	030093	01.2457
010010	01.1173	010079	01.1452	010143	01.1228	030023	01.2050	030094	01.2766
010011	01.3551	010080	00.9592	010144	01.3789	030024	01.6287	030098	00.5181
010012	01.1931	010081	01.8040	010145	01.2057	030025	01.0787	030099	00.5200
010015	01.0675	010083	01.0991	010146	01.0427	030027	01.0654	040001	01.0683
010016	01.0742	010084	01.2935	010148	00.9513	030030	01.6518	040002	01.1373
010018	00.9098	010085	01.2727	010149	01.3680	030033	01.3712	040003	01.0324
010019	01.1735	010086	00.9632	010150	01.0031	030034	01.0249	040004	01.2185
010020	01.0072	010087	01.5119	010152	01.2610	030035	01.2448	040005	01.0502
010021	01.2132	010088	01.0956	010153	00.9070	030036	01.2282	040007	01.5284
010022	00.9360	010089	01.4736	010155	01.1117	030037	01.8874	040008	01.0195
010023	01.2700	010091	01.0218	010158	00.5196	030038	01.4584	040010	01.1381
010024	01.2319	010092	01.3452	010159	00.5200	030040	00.9766	040011	00.9208
010025	01.2143	010094	01.1822	020001	01.4754	030041	00.9497	040013	00.9658
010027	00.8636	010095	00.9042	020002	01.1956	030043	01.1944	040014	01.1036
010029	01.4907	010096	00.9042	020004	01.0918	030044	01.1142	040015	01.0686
010031	01.2842	010097	01.0094	020005	00.9051	030046	00.9643	040016	01.4734
010032	00.8913	010098	01.0222	020006	01.0468	030047	00.9250	040017	01.2387
010033	01.9377	010099	01.0824	020007	00.8787	030049	00.9363	040018	01.2086
010034	01.0469	010100	01.1729	020008	01.0333	030051	01.0265	040019	01.1872
010035	01.1685	010101	01.0592	020009	00.8031	030054	00.9012	040020	01.4510
010036	01.1452	010102	00.9106	020010	00.9000	030055	01.1982	040021	01.2032
010038	01.2322	010103	01.5427	020011	00.9370	030059	01.3750	040022	01.6969
010039	01.5834	010104	01.5701	020012	01.1503	030060	01.1305	040024	01.0838
010040	01.2840	010108	01.1551	020013	00.8702	030061	01.4277	040025	00.8924
010043	00.9584	010109	01.0717	020014	00.9537	030062	01.2495	040026	01.4369
010044	00.9788	010110	00.9124	020017	01.3518	030064	01.5417	040027	01.2740
010045	01.0010	010112	01.1436	020018	00.8783	030065	01.4484	040028	00.9902
010046	01.3147	010113	01.5935	020019	00.9422	030067	01.0552	040029	01.0888
010047	00.9028	010114	01.1846	020021	00.9005	030068	01.0987	040030	00.9164
010049	01.0790	010115	00.8953	020024	01.0287	030069	01.2789	040031	00.9815
010050	00.9491	010117	01.1050	020025	01.0213	030071	00.9640	040032	00.9272
010051	00.8287	010118	01.1373	020026	00.8182	030072	00.8799	040035	00.9102
010052	00.9674	010119	01.1974	020027	00.8167	030073	01.0323	040036	01.2323
010053	01.0179	010120	00.9855	030001	01.3617	030074	01.0497	040037	01.1350
010054	01.1925	010121	01.1050	030002	01.7349	030075	00.9453	040039	01.0616
010055	01.3289	010122	00.9577	030003	01.3318	030076	01.0423	040040	00.9931
010056	01.2851	010123	01.2930	030004	00.9855	030077	01.0864	040041	01.1299
010057	01.0122	010124	01.2847	030006	01.5760	030078	01.0864	040042	01.3037
010058	00.9253	010125	01.0912	030007	01.2757	030079	00.7815	040044	00.9218
010059	00.9964	010126	01.0751	030008	01.8925	030080	01.5166	040045	00.9477
010061	00.9627	010127	01.5091	030009	01.2164	030083	01.3440	040047	01.0546
010062	00.9473	010128	00.8857	030010	01.4319	030084	01.1458	040048	01.2052
010064	01.6492	010129	01.0542	030011	01.3722	030085	01.3881	040050	01.1061

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH DECEMBER 1991

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
040051	01.0291	050009	01.6032	050075	01.2735	050137	01.2678	050212	01.1063
040053	01.0340	050013	02.1233	050076	01.4847	050138	01.7065	050213	01.3622
040054	00.9467	050014	01.0837	050077	01.6442	050139	01.2130	050214	01.5456
040055	01.3270	050015	01.4664	050078	01.3218	050140	01.2963	050215	01.4141
040058	00.9101	050016	01.1859	050079	01.5001	050143	01.4018	050217	01.2034
040060	00.9745	050017	02.0086	050080	01.2194	050144	01.4952	050219	01.3608
040062	01.3459	050018	01.2656	050081	01.6186	050145	01.2839	050220	01.2477
040063	01.4385	050019	00.8019	050082	01.4811	050146	01.3042	050222	01.5161
040064	00.9033	050021	01.2692	050084	01.4887	050147	00.7626	050224	01.6179
040066	01.0287	050022	01.5469	050087	01.1730	050148	01.1279	050225	01.3268
040067	01.0078	050024	01.3713	050088	01.1475	050149	01.3523	050226	01.4244
040069	01.0531	050025	01.6700	050089	01.3437	050150	01.2418	050228	01.2684
040070	00.9627	050026	01.4750	050090	01.2347	050152	01.3937	050230	01.3319
040071	01.4115	050028	01.2694	050091	01.2234	050153	01.6399	050231	01.4916
040072	01.0749	050029	01.3282	050092	00.9544	050154	01.2079	050232	01.8523
040074	01.1782	050030	01.2953	050093	01.5279	050155	01.0988	050233	01.2233
040075	01.1030	050032	01.2800	050095	01.8435	050158	01.6873	050234	01.2788
040076	01.0457	050033	01.3889	050096	01.0950	050159	01.3846	050235	01.4955
040077	00.9271	050034	01.3112	050097	01.4334	050161	01.5247	050236	01.3804
040078	01.2381	050036	01.7073	050099	01.6580	050166	01.0544	050238	01.5048
040080	01.0666	050038	01.4042	050100	01.8096	050167	01.3769	050239	01.4072
040081	00.8585	050039	01.6455	050101	01.3540	050168	01.6897	050240	01.4357
040082	01.2073	050040	01.1085	050102	01.2768	050169	01.4897	050242	01.3914
040084	01.1230	050041	01.2975	050103	01.4970	050170	01.3293	050243	01.4666
040085	01.1277	050042	01.2151	050104	01.3516	050172	01.2464	050245	01.4073
040088	01.2199	050043	01.5635	050107	01.4279	050174	01.5976	050248	01.1128
040090	00.9564	050045	01.2640	050108	01.4279	050175	01.4123	050251	01.1629
040091	01.1591	050046	01.1789	050109	02.0895	050177	01.2383	050254	01.1301
040093	01.0163	050047	01.6959	050110	01.1486	050179	01.2320	050256	01.6689
040095	00.8770	050049	01.5929	050111	01.2768	050180	01.4036	050257	01.1402
040100	01.1257	050051	01.1437	050112	01.4440	050181	01.2676	050258	01.2483
040105	01.0186	050053	01.2884	050113	01.1630	050183	01.1229	050260	00.9182
040106	01.1743	050054	01.2674	050114	01.4689	050186	01.3243	050261	01.1815
040107	01.0535	050055	01.2658	050115	01.4645	050188	01.3669	050262	01.7402
040109	01.1405	050056	01.3653	050116	01.4446	050189	00.9111	050263	01.2485
040114	01.7018	050057	01.4435	050117	01.3078	050191	01.3797	050264	01.4181
040115	01.0638	050058	01.4070	050118	01.1611	050192	01.1773	050267	01.5090
040116	01.3735	050060	01.4525	050121	01.2749	050193	01.3451	050269	01.0991
040118	01.1913	050061	01.2547	050122	01.4136	050194	01.3375	050270	01.3084
040119	01.1378	050063	01.3386	050124	01.2015	050195	01.5291	050272	01.3138
040122	01.0989	050065	01.5143	050125	01.2918	050196	01.2749	050274	00.9718
040124	01.0802	050066	01.2789	050126	01.3895	050197	01.9148	050276	01.1388
040126	00.9696	050067	01.2796	050127	01.2513	050199	01.2346	050277	01.4033
040132	01.4616	050068	01.1265	050128	01.4923	050201	00.9045	050278	01.4025
040898	00.5196	050069	01.5878	050129	01.5417	050204	01.4017	050279	01.2145
040899	00.5200	050070	01.1970	050131	01.2596	050205	01.2219	050280	01.4567
050002	01.2967	050071	01.3146	050132	01.3999	050207	01.2349	050281	01.2718
050006	01.2959	050072	01.2163	050133	01.1862	050208	01.1981	050282	01.2748
050007	01.4748	050073	01.2151	050135	01.3006	050211	01.3124	050283	01.4291
050008	01.3865	050074	01.0344	050136	01.2961				

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.

: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH DECEMBER 1991

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
050286	01.0244	050369	01.2706	050448	01.0819	050539	01.1954	050609	01.2933
050289	01.6764	050373	01.3800	050449	01.2931	050541	01.4811	050613	01.0819
050290	01.4731	050376	01.3023	050450	00.8056	050542	01.1247	050615	01.3968
050291	01.1747	050377	00.9904	050451	00.9648	050543	01.3982	050616	01.3301
050292	01.1348	050378	01.1644	050454	01.6526	050545	00.9304	050618	01.1719
050293	01.3058	050379	01.1386	050455	01.8496	050546	01.1350	050619	01.3693
050295	01.3292	050380	01.6015	050456	01.3863	050547	00.9116	050622	01.0777
050296	01.1106	050382	01.4337	050457	01.8000	050549	01.7832	050623	01.1558
050298	01.2188	050385	01.3214	050458	00.9333	050550	01.1040	050624	01.2954
050299	01.2423	050387	00.9417	050459	01.2557	050551	01.2649	050625	01.4842
050300	01.2945	050388	00.9504	050464	01.7938	050552	01.0653	050626	01.2453
050301	01.1870	050390	01.2280	050467	01.2370	050557	01.5074	050630	01.2234
050302	01.2706	050391	01.4178	050468	01.6302	050559	01.2590	050633	01.2962
050305	01.4602	050392	00.9559	050469	01.0978	050560	01.2821	050635	01.2819
050307	01.4068	050393	01.5017	050470	01.1291	050561	01.1587	050637	01.1627
050308	01.5480	050394	01.4718	050471	01.7540	050564	01.3160	050638	01.0131
050309	01.2966	050396	01.5810	050476	01.2644	050565	01.1196	050641	01.1309
050310	01.2352	050397	00.8738	050477	01.3904	050566	01.0216	050643	00.8934
050312	01.7651	050401	01.1898	050478	01.0005	050567	01.6121	050644	01.0971
050313	01.1686	050404	01.0481	050481	01.4764	050568	01.3153	050649	01.1482
050315	01.2833	050406	01.0903	050482	01.0299	050569	01.2062	050651	01.2751
050317	01.2069	050407	01.0341	050483	01.2493	050570	01.6957	050655	00.7803
050320	01.3202	050410	00.8314	050485	01.7390	050571	01.4054	050660	01.1220
050324	01.8365	050411	01.3054	050486	01.4141	050573	01.6318	050661	00.8980
050325	01.2841	050414	01.2608	050488	01.1990	050575	01.2308	050662	00.9940
050327	01.6173	050417	01.1647	050489	01.0803	050577	01.3060	050666	00.9618
050328	01.2477	050418	01.3164	050491	01.4395	050578	01.4097	050667	01.1048
050329	01.2414	050419	01.2788	050492	01.2545	050579	01.4477	050668	01.0151
050331	01.2894	050420	01.3644	050494	01.0906	050580	01.2579	050668	01.1684
050333	01.0028	050421	01.3308	050496	01.7941	050581	01.3583	050669	00.7493
050334	01.4687	050423	01.0499	050497	00.7812	050583	01.7159	050670	01.2287
050335	01.2418	050424	01.6884	050498	01.1462	050584	01.2776	050671	01.1525
050336	01.2370	050425	01.3100	050498	01.6770	050585	01.3653	050672	00.6859
050337	01.2174	050426	01.3732	050502	01.2981	050586	01.3371	050674	01.1831
050342	01.3071	050427	00.9738	050506	01.4730	050587	01.2359	050675	01.5231
050343	01.0348	050430	00.9661	050510	01.2397	050588	01.2718	050676	00.9970
050345	01.3605	050431	01.0448	050512	01.2454	050589	01.3564	050677	01.2951
050348	01.7029	050432	01.6131	050515	01.3163	050590	01.3075	050678	01.1900
050349	01.0077	050433	01.1511	050516	01.3388	050591	01.1236	050680	01.1784
050350	01.4095	050434	01.1019	050517	01.3889	050592	01.2864	050682	00.9421
050351	01.4804	050435	01.2896	050522	01.3364	050593	01.2619	050684	01.2152
050352	01.2587	050436	01.0104	050523	01.2422	050594	01.9607	050685	01.1468
050353	01.6574	050438	01.4773	050526	01.3684	050597	01.3571	050686	01.2813
050355	00.9837	050440	01.2045	050527	01.2051	050598	01.3543	050688	01.1468
050357	01.8126	050441	01.7390	050528	01.2075	050599	01.6492	050689	01.3497
050359	01.1197	050442	00.8510	050530	00.9026	050601	01.3017	050690	01.1960
050360	01.4326	050443	00.9028	050531	01.2815	050603	01.4267	050691	00.9533
050363	01.3267	050444	01.2352	050534	01.4063	050604	01.4106	050693	01.2499
050366	01.2918	050446	00.8811	050535	01.3038	050607	01.2276	050694	01.1491
050367	01.2376	050447	01.0390	050537	01.2255	050608	01.1783	050695	01.2229

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.

: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH DECEMBER 1991

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
050696	01.7667	060062	00.9905	070028	01.4868	100021	01.3539	100078	01.1933
050898	00.5184	060063	01.1643	070029	01.2278	100022	01.6030	100080	01.5876
050899	00.5200	060064	01.3338	070030	01.2712	100023	01.3257	100081	01.0850
060001	01.4473	060065	01.3338	070031	01.3064	100024	01.2561	100082	01.3652
060003	01.2174	060066	00.9210	070033	01.3594	100025	01.5092	100083	01.3256
060004	01.0625	060068	01.1559	070034	01.2937	100026	01.4216	100084	01.3015
060005	01.7634	060070	01.1378	070035	01.3635	100027	00.8915	100085	01.3420
060006	01.1687	060071	01.0907	070036	01.3354	100028	01.2884	100086	01.2972
060007	01.1705	060072	00.9116	070038	00.6890	100029	01.3160	100087	01.7275
060008	01.0566	060073	01.0022	070898	00.5192	100030	01.5126	100088	01.5126
060009	01.3422	060074	00.8741	070899	00.5200	100032	01.7739	100089	01.2576
060010	01.5323	060075	01.2877	080001	01.5986	100034	01.6068	100090	01.3009
060011	01.2398	060076	01.3972	080002	01.1482	100035	01.4708	100092	01.3309
060012	01.4429	060085	00.8856	080003	01.2470	100038	01.6027	100093	01.5400
060013	01.1587	060087	01.4029	080004	01.2425	100039	01.6078	100098	01.0255
060014	01.6576	060088	01.1095	080005	01.1541	100040	01.6453	100099	01.2760
060015	01.4507	060090	00.9544	080006	01.1587	100042	01.2676	100100	01.2561
060016	01.1624	060096	01.0348	080007	01.2412	100043	01.3730	100102	01.2052
060018	01.1716	060100	01.3752	080898	00.5196	100044	01.4116	100103	01.0123
060020	01.4510	060101	01.3241	080899	00.5200	100045	01.3840	100105	01.3779
060022	01.5650	060102	04.0098	090001	01.4324	100046	01.3314	100106	01.1455
060023	01.4318	060103	01.3942	090002	01.1968	100047	01.5519	100107	01.2547
060024	01.5904	060104	01.2421	090003	01.4211	100048	00.9518	100108	01.1039
060026	01.3897	070001	01.7935	090004	01.5339	100049	01.3471	100109	01.2356
060027	01.4832	070002	01.7754	090005	01.2647	100050	01.2169	100110	01.3936
060028	01.3114	070003	01.1715	090006	01.3010	100051	01.2891	100112	00.9398
060029	01.0063	070004	01.1316	090007	01.2671	100052	01.3159	100113	01.9434
060030	01.3033	070005	01.2877	090008	01.3742	100053	01.2670	100114	01.4608
060031	01.4095	070006	01.2630	090009	01.2280	100054	01.3836	100117	01.2908
060032	01.3503	070007	01.3738	090010	00.9452	100055	01.3523	100118	01.1757
060033	01.1385	070008	01.2364	090011	01.8691	100056	01.5729	100121	01.1084
060034	01.3380	070009	01.2975	090898	00.5247	100057	01.3440	100122	01.3107
060036	01.1230	070010	01.4696	090899	00.5200	100059	01.5216	100124	01.3007
060037	01.0147	070011	01.1991	100001	01.3999	100060	01.7630	100125	01.1734
060038	01.1302	070012	01.2447	100002	01.4195	100061	01.4898	100126	01.4681
060041	01.0393	070013	01.3400	100004	01.0160	100062	01.6713	100127	01.5839
060042	00.9514	070014	01.2508	100005	00.9181	100063	01.3037	100128	02.2774
060043	00.9036	070015	01.2474	100006	01.6073	100065	01.2895	100129	01.3777
060044	01.2120	070016	01.2964	100007	01.8771	100067	01.3848	100130	01.1884
060046	01.1247	070017	01.2853	100008	01.7168	100068	01.4241	100131	01.2148
060047	01.1706	070018	01.3011	100009	01.4227	100069	01.3902	100132	01.2970
060049	01.0782	070019	01.1736	100010	01.3955	100070	01.3118	100134	00.9987
060050	01.2190	070020	01.3566	100012	01.5492	100071	01.3919	100135	01.5116
060052	01.0024	070021	01.2052	100014	01.3253	100072	01.1614	100137	01.1324
060053	01.0392	070022	01.6674	100015	01.4018	100073	01.8211	100138	00.9728
060054	01.3065	070023	01.2590	100016	01.0734	100074	01.2326	100139	01.0604
060056	00.9142	070024	01.1946	100017	01.6853	100075	01.7370	100140	01.1142
060057	01.0967	070025	01.6569	100018	01.3501	100076	01.2951	100142	01.1543
060058	00.8810	070026	01.2481	100019	01.4850	100077	01.3021	100143	01.2479
060060	01.0164	070027	01.2134	100020	01.3049	100078	01.1467	100144	01.2115

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH DECEMBER 1991

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
100145	01.3976	100218	00.8935	100277	01.0002	110051	01.0654	110115	01.5804
100146	01.0737	100219	01.3945	100278	00.6969	110052	00.9595	110117	01.0814
100147	01.0807	100220	01.6886	100279	01.2692	110054	01.2231	110118	01.0345
100150	01.4351	100221	01.5400	100898	00.5185	110055	00.8784	110120	01.0454
100151	01.7286	100222	01.2188	100899	00.5200	110056	00.9984	110121	01.1181
100152	01.2548	100223	01.4274	110001	01.1514	110059	01.3499	110122	01.3054
100154	01.5992	100224	01.3180	110002	01.2126	110061	00.9985	110123	00.8407
100156	01.0467	100225	01.3578	110003	01.2787	110062	00.9273	110124	01.0725
100157	01.4911	100226	01.3231	110004	01.2388	110063	01.0321	110125	01.1430
100159	01.0496	100227	00.9950	110005	01.4177	110064	01.2389	110127	00.9568
100160	01.1839	100228	01.2705	110006	01.2823	110065	01.0074	110128	01.1580
100161	01.5007	100229	01.4521	110007	01.3635	110066	01.2479	110129	01.5818
100162	01.3001	100230	01.2808	110008	01.1223	110069	01.1940	110130	00.9843
100164	00.9880	100231	01.7172	110009	01.0997	110070	00.9516	110132	01.1278
100165	01.1703	100232	01.3095	110010	01.8836	110071	01.0340	110133	00.8938
100166	01.4899	100234	01.3452	110011	01.1478	110072	01.0001	110134	00.8857
100167	01.3349	100235	01.3245	110013	00.9991	110073	01.2378	110135	01.1668
100168	01.2989	100236	01.3256	110014	01.0282	110074	01.2521	110136	01.0652
100169	01.7901	100237	02.0925	110015	01.0553	110075	01.2141	110140	00.8749
100170	01.4164	100238	01.4005	110016	01.2323	110076	01.3575	110141	00.8966
100172	01.3735	100239	01.4278	110017	00.9219	110078	01.5955	110142	01.1064
100173	01.5659	100240	00.8747	110018	01.1568	110079	01.2925	110143	01.2768
100174	01.3582	100241	00.9983	110020	01.1523	110080	01.0696	110144	01.2225
100175	01.0843	100242	01.3139	110023	01.1944	110082	02.0548	110146	00.9286
100176	01.9514	100243	01.3886	110024	01.3733	110083	01.4758	110149	01.0948
100177	01.3284	100244	01.3431	110025	01.2896	110085	01.1683	110150	01.2360
100179	01.7186	100246	01.3684	110026	01.0925	110086	01.0764	110151	00.9851
100180	01.4036	100248	01.6913	110027	01.0390	110087	01.2570	110152	01.0209
100181	01.3168	100249	01.2949	110028	01.5457	110088	00.9019	110153	01.0076
100183	01.3387	100252	01.3774	110029	01.2975	110089	01.1032	110154	00.9383
100185	01.2200	100253	01.3636	110030	01.1894	110091	01.2712	110155	01.0529
100186	01.3615	100254	01.6109	110031	01.3160	110092	01.0649	110156	00.9185
100187	01.3159	100255	01.3767	110032	01.1149	110093	00.9367	110157	01.0762
100189	01.3613	100256	01.7268	110033	01.3365	110094	01.0202	110161	01.2659
100191	01.3664	100258	01.6919	110034	01.3826	110095	01.3300	110162	00.8024
100194	01.2544	100259	01.4074	110035	01.3233	110096	01.1470	110163	01.3459
100196	01.2477	100260	01.4020	110036	01.5187	110097	01.1070	110164	01.3095
100199	01.1715	100262	01.3357	110037	01.0781	110098	01.0151	110165	01.1870
100200	01.3521	100263	01.4525	110038	01.3267	110100	01.0974	110166	01.3463
100203	01.0816	100264	01.3878	110039	01.3182	110101	01.0193	110168	01.6421
100204	01.5665	100265	01.2780	110040	00.9111	110103	00.9414	110169	00.7656
100206	01.3603	100266	01.3124	110041	01.0631	110104	01.1317	110171	01.3361
100207	01.3851	100267	01.2256	110042	01.0593	110105	01.1648	110172	01.1566
100208	01.5129	100268	01.2607	110043	01.5546	110107	01.6075	110174	00.8708
100209	01.5320	100269	01.4203	110044	01.1330	110108	00.9009	110176	01.1209
100210	01.6637	100270	00.9083	110045	01.0170	110109	01.1164	110177	01.3922
100211	01.2674	100271	01.5639	110046	01.1779	110111	01.1600	110178	01.1896
100212	01.6383	100273	01.1320	110048	01.1276	110112	00.9343	110179	01.1987
100213	01.6177	100275	01.2894	110049	01.0904	110113	00.9223	110181	00.9519
100217	01.1787	100276	01.3800	110050	01.0831	110114	01.1558	110183	01.3344

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.

: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH DECEMBER 1991

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
140203	01.1337	140898	00.5181	150053	01.0470	150112	01.1982	160040	01.3668
140205	00.9551	140899	00.5200	150054	01.0497	150113	01.2270	160041	01.1382
140206	01.1013	150001	01.0866	150056	01.6901	150114	01.0611	160043	00.9578
140207	01.2690	150002	01.3312	150057	02.2253	150115	01.2867	160044	01.2367
140208	01.4229	150003	01.6251	150058	01.5508	150122	01.0794	160045	01.6074
140209	01.5752	150004	01.3044	150059	01.2186	150123	00.9503	160046	01.0336
140210	01.0445	150005	01.2138	150060	01.1671	150124	01.1739	160047	01.4127
140211	01.1326	150006	01.2403	150061	01.1838	150125	01.3873	160048	01.0440
140212	01.2870	150007	01.1829	150062	01.0910	150126	01.5358	160049	00.8982
140213	01.1873	150008	01.3416	150063	01.1227	150127	01.1294	160050	01.0342
140215	01.0482	150009	01.2908	150064	01.0567	150128	01.1622	160051	01.2973
140217	01.2319	150010	01.1783	150065	01.1089	150129	01.2726	160052	00.9844
140218	00.9885	150011	01.2436	150066	01.1213	150130	01.1040	160054	01.0653
140220	01.1372	150012	01.5638	150067	01.0741	150132	01.3831	160055	01.0042
140223	01.5118	150013	01.2096	150069	01.2334	150133	01.2568	160056	01.0445
140224	01.3121	150014	01.3494	150070	01.0998	150134	01.1592	160057	01.3591
140226	00.9456	150015	01.2179	150071	01.1540	150135	00.8683	160058	01.6085
140228	01.5306	150017	01.6638	150072	01.2506	150136	01.0943	160059	01.2371
140229	00.9738	150018	01.2399	150073	01.0332	150898	00.5281	160060	01.0625
140230	00.9463	150019	01.1710	150074	01.4884	150899	00.5200	160061	00.9922
140231	01.5672	150020	01.1315	150075	01.2291	160001	01.1459	160062	00.9161
140233	01.6464	150021	01.6037	150076	01.0504	160002	01.2211	160063	01.1777
140234	01.1276	150022	01.1080	150077	01.1840	160003	01.0661	160064	01.5250
140236	00.9992	150023	01.3798	150078	01.0674	160005	01.0823	160065	01.1123
140239	01.5783	150024	01.1862	150079	01.1606	160007	00.9661	160066	01.0640
140240	01.2534	150025	01.5246	150082	01.3845	160008	01.0831	160067	01.2509
140242	01.4056	150026	01.1850	150084	01.6722	160009	01.1237	160068	01.0595
140245	01.0278	150027	00.9988	150085	00.9949	160012	01.1698	160069	01.3451
140246	01.0286	150029	01.2366	150086	01.2448	160014	01.2526	160070	01.1470
140250	01.2315	150030	01.1538	150088	01.1321	160014	00.9603	160071	01.1085
140251	01.2873	150031	01.0737	150089	01.2705	160016	01.2805	160072	01.0487
140252	01.2874	150032	01.6708	150090	01.2714	160018	00.9803	160073	00.9101
140253	01.2978	150033	01.5674	150091	01.2142	160020	01.0945	160074	01.0358
140258	01.3986	150034	01.2955	150092	01.1555	160021	01.1472	160075	01.0646
140271	01.0257	150035	01.4004	150094	01.0387	160023	01.0519	160076	00.9608
140275	01.1750	150036	00.9985	150095	01.1019	160024	01.4478	160077	01.1110
140276	02.0314	150037	01.2045	150096	00.9955	160025	01.8087	160079	01.2838
140280	01.1492	150038	01.2351	150097	01.0369	160026	01.0294	160080	01.1229
140281	01.5020	150039	00.9896	150098	01.0412	160027	01.1317	160081	01.0832
140285	01.2689	150042	01.1886	150099	01.2931	160028	01.2531	160082	01.6677
140286	01.1101	150043	01.0538	150100	01.5883	160029	01.4546	160083	01.5479
140288	01.5924	150044	01.2313	150101	01.0645	160030	01.3108	160085	01.1158
140289	01.2836	150045	01.1570	150102	01.1126	160031	01.0375	160086	01.0256
140290	01.3853	150046	01.4045	150103	01.1413	160032	01.0543	160088	01.0229
140291	01.2536	150047	01.6539	150104	01.1703	160033	01.3345	160089	01.2044
140292	01.1840	150048	01.1880	150105	01.1905	160034	01.0049	160090	01.0593
140294	01.0794	150049	01.0822	150106	01.0667	160035	00.9184	160091	01.1440
140295	03.2098	150050	01.1867	150109	01.2663	160036	01.0409	160092	00.9561
140297	01.4023	150051	01.2354	150110	00.8906	160037	01.0126	160093	01.1058
140299	00.8975	150052	01.0362	150111	01.0951	160039	01.0469	160094	01.1664

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.

: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH DECEMBER 1991

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
180095	01.0190	170007	01.1100	170084	01.1682	170123	01.6819	180018	01.1547
180096	01.1524	170008	01.0001	170085	00.9287	170124	00.9698	180019	01.1754
180097	00.9580	170009	01.1568	170086	01.0338	170125	00.9370	180020	01.0113
180098	01.0951	170010	01.1230	170087	01.2346	170126	00.9533	180021	00.8952
180099	01.1584	170011	01.3507	170088	00.8681	170127	00.9943	180022	00.8405
180100	01.4309	170012	01.4250	170089	01.0500	170128	01.1240	180023	01.1986
180101	00.9021	170013	01.1395	170090	00.9415	170129	01.1704	180024	01.1341
180102	01.1303	170014	01.0569	170091	01.1247	170130	00.9724	180025	01.1069
180103	01.0243	170015	01.0876	170092	01.1820	170131	01.1588	180026	01.1579
180104	01.1143	170016	01.5492	170093	00.8509	170132	01.1588	180027	00.9895
180105	01.1360	170017	01.1552	170094	01.1261	170133	01.0344	180028	01.2787
180106	00.9435	170018	01.1002	170095	00.9625	170134	01.2568	180029	01.1421
180107	01.5132	170019	01.1755	170096	00.9817	170135	01.0926	180030	01.0028
180108	01.1020	170020	01.2224	170097	00.9468	170136	01.1424	180031	00.9845
180109	01.3806	170021	00.8705	170098	01.1629	170137	01.1424	180032	01.0804
180110	01.0430	170022	01.1900	170099	00.9078	170138	01.2109	180033	01.0138
180111	00.9986	170023	01.3028	170100	00.9100	170139	01.3142	180034	01.4403
180112	01.0089	170024	01.1041	170101	00.9514	170140	01.3324	180035	01.1042
180113	01.1581	170025	01.4256	170102	01.8350	170141	01.1269	180036	01.2745
180114	01.3205	170026	00.9911	170103	01.3417	170142	01.0010	180037	01.3231
180115	00.9801	170027	01.1585	170104	00.9295	170143	00.9193	180038	01.9484
180116	00.8656	170028	00.9718	170105	01.0006	170144	00.9105	180039	01.0778
180117	01.0034	170029	00.8778	170106	00.9957	170145	00.9690	180040	01.0364
180118	01.2228	170030	01.0526	170107	00.8583	170146	01.0938	180041	01.0120
180119	01.0963	170031	01.2046	170108	01.0164	170147	01.0144	180042	01.0752
180120	01.1753	170032	00.9560	170109	01.0047	170148	00.8770	180043	01.1535
180121	01.1345	170033	00.8789	170110	01.1818	170149	00.8537	180044	01.0595
180122	01.1714	170034	00.9473	170111	00.9439	170150	01.1421	180045	01.0280
180123	01.2586	170035	01.1591	170112	01.0287	170151	01.0228	180046	01.2029
180124	01.1591	170036	00.9980	170113	01.3981	170152	00.8276	180047	01.3388
180125	01.1978	170037	01.1149	170114	00.8458	170153	00.9455	180048	01.3006
180126	00.8912	170038	01.4044	170115	00.9798	170154	01.2206	180049	01.1855
180127	01.0161	170039	01.0247	170116	01.4366	170155	01.4126	180050	01.1855
180128	01.0688	170040	01.0831	170117	01.2120	170156	00.5200	180051	01.0952
180129	00.9225	170041	01.2601	170118	00.9795	170157	01.1551	180052	01.0818
180130	01.1504	170042	01.3084	170119	00.8874	170158	01.1152	180053	01.0455
180131	01.1120	170043	00.9449	170120	00.9018	170159	01.1859	180054	00.9059
180132	00.9893	170044	00.9698	170121	01.0129	170160	01.0705	180055	00.9006
180133	01.3139	170045	01.0973	170122	00.9777	170161	00.9389	180056	00.9007
180134	01.2251	170046	00.8526	170123	00.9233	170162	00.8008	180057	00.8039
180135	01.1450	170047	01.0861	170124	01.0559	170163	01.4146	180058	01.0271
180136	01.0275	170048	01.0842	170125	01.0559	170164	01.1758	180059	01.0549
180137	01.5606	170049	00.9901	170126	01.0858	170165	00.9945	180060	00.9945
180138	00.5198	170050	01.0282	170127	01.1130	170166	01.0951	180061	01.1690
180139	00.5200	170051	01.0342	170128	00.9549	170167	01.2608	180062	01.8854
170001	01.1790	170052	01.0250	170129	00.9609	170168	01.3258	180063	01.0757
170002	01.1970	170053	00.9558	170130	01.2157	170169	01.5881	180064	01.0676
170003	01.0552	170054	00.8460	170131	00.7845	170170	01.1107	180065	01.0910
170004	01.2423	170055	00.9227	170132	01.8009	170171	01.2027	180066	00.9465
170005	01.2423	170056	00.9227	170133	01.8009	170172	01.2178	180067	01.0110

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH DECEMBER 1991

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
180078	01.0158	190009	01.0869	190098	01.3473	190175	01.8435	200026	00.9964
180080	01.1259	190010	00.9124	190099	01.1842	190176	01.4020	200027	01.0818
180081	01.3845	190011	01.0851	190102	01.4314	190177	01.4911	200028	01.0834
180085	01.3268	190013	01.2197	190103	00.9018	190178	00.9785	200031	01.2848
180087	00.8848	190014	00.9372	190106	01.1609	190182	01.0160	200032	01.2705
180088	01.6284	190015	01.1928	190109	01.0862	190183	01.0784	200033	01.6831
180089	01.1040	190017	01.2233	190110	00.9627	190184	00.9008	200034	01.1733
180093	01.3912	190018	01.1515	190111	01.5638	190185	01.2377	200037	01.1608
180094	00.9914	190019	01.4994	190112	01.2865	190186	00.9504	200038	00.9959
180095	00.9731	190020	01.1497	190113	01.2819	190187	00.6374	200039	01.3038
180099	00.9826	190023	00.6808	190114	00.9300	190189	01.0927	200040	01.0448
180101	01.2639	190025	01.2591	190115	01.2984	190190	00.9928	200041	01.1624
180102	01.3959	190026	01.3084	190116	01.2175	190191	01.2145	200043	00.6671
180103	01.7911	190027	01.3861	190118	00.9955	190193	01.1726	200044	01.1551
180104	01.3908	190029	01.2525	190120	00.8999	190194	01.1263	200050	01.1164
180105	00.9756	190033	00.9577	190122	01.1389	190196	00.8327	200051	00.9915
180106	00.9030	190034	01.2263	190124	01.4427	190197	01.1954	200052	01.0318
180108	00.9008	190035	01.3867	190125	01.3857	190198	01.1925	200055	01.0359
180115	00.9735	190036	01.6053	190127	01.4642	190199	01.2482	200062	00.9688
180116	01.2722	190037	00.9829	190128	00.8335	190200	01.5711	200063	01.2191
180117	01.2493	190039	01.4224	190130	00.9213	190201	01.2052	200066	01.1383
180118	01.0100	190040	01.3537	190131	01.2685	190202	01.4030	200898	00.5196
180120	00.9155	190041	01.5700	190132	01.0487	190203	01.6192	200899	00.5200
180121	01.0528	190043	01.0344	190133	01.0881	190204	01.4483	210001	01.3113
180122	00.9433	190044	01.0859	190134	00.9965	190205	01.3582	210002	01.8102
180123	01.4493	190045	01.2702	190135	01.3406	190206	01.4580	210003	01.3679
180124	01.3235	190046	01.4276	190136	01.0275	190207	01.1789	210004	01.2692
180125	01.0289	190047	01.1513	190138	00.7591	190208	00.8650	210005	01.2031
180126	01.0185	190048	00.9815	190140	00.9931	190211	00.9095	210006	01.0709
180127	01.1529	190049	00.9832	190142	00.9274	190212	00.8972	210007	01.4240
180128	01.1070	190050	01.0377	190144	01.1443	190213	00.7888	210008	01.2671
180129	01.0511	190053	01.0173	190145	00.9276	200001	01.3061	210009	01.6115
180130	01.3826	190054	01.3866	190146	01.4486	200002	01.0690	210010	01.1401
180132	01.3115	190059	00.9473	190147	00.9627	200003	01.0446	210011	01.2918
180133	01.2250	190060	01.2367	190148	00.9486	200006	01.0578	210012	01.4586
180134	01.0809	190064	01.4478	190149	00.9899	200007	01.0300	210013	01.2890
180136	01.2741	190085	01.4534	190151	01.0827	200008	01.2206	210015	01.2112
180137	01.7549	190071	00.8912	190152	01.4163	200009	01.6701	210016	01.7479
180138	01.2003	190075	01.4406	190155	00.9153	200012	01.1630	210017	01.1426
180139	01.0273	190077	00.8830	190156	00.8454	200013	01.1053	210018	01.2121
180898	00.5196	190078	01.1689	190158	01.2932	200015	01.2727	210019	01.3329
180899	00.5200	190079	01.2161	190160	01.1167	200016	01.0312	210021	01.2554
190001	00.8958	190081	00.8791	190161	00.8674	200017	01.3041	210022	01.3115
190002	01.5643	190083	00.8729	190162	01.2630	200018	01.1012	210023	01.2724
190003	01.3795	190086	01.2142	190164	01.0565	200019	01.2165	210024	01.2451
190004	01.1471	190088	01.3358	190165	01.0670	200020	01.0701	210025	01.2536
190005	01.3164	190089	01.0645	190166	01.0047	200021	01.1376	210026	01.3391
190006	01.0955	190090	01.1977	190167	01.2954	200022	00.7971	210027	01.1947
190007	01.0465	190092	01.1615	190170	01.0008	200024	01.1752	210028	01.0626
190008	01.4282	190095	01.0355	190173	01.4337	200025	01.1447	210029	01.3446

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.

: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH DECEMBER 1991

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991

PAGE 10 OF 23

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
210030	01.0595	220036	01.4834	220105	01.1695	230032	01.6964	230104	01.5790
210031	01.4051	220038	01.2598	220106	01.1035	230034	01.1744	230105	01.4711
210032	01.1903	220041	01.1661	220107	01.1500	230035	01.1663	230106	01.1156
210033	01.1204	220042	01.1514	220108	01.1383	230036	01.2841	230107	01.0171
210034	01.1897	220045	01.1892	220110	01.9168	230037	01.2856	230108	01.1981
210035	01.1484	220046	01.3591	220111	01.1722	230038	01.5726	230110	01.2223
210036	01.2133	220048	01.1725	220114	01.0710	230039	01.2712	230111	01.0475
210037	01.1863	220049	01.1742	220115	01.2616	230040	01.3120	230113	01.0260
210038	01.3598	220050	00.9942	220116	01.7618	230041	01.1222	230114	00.7155
210039	01.2021	220051	01.2208	220118	01.9112	230042	01.0850	230115	01.0244
210040	01.3506	220052	01.2323	220119	01.3504	230046	01.7675	230116	00.9016
210043	01.1926	220053	01.2760	220120	00.9899	230047	01.2111	230117	01.7895
210044	01.1942	220055	01.1789	220123	00.9522	230053	01.4494	230118	01.2659
210045	00.9678	220057	01.1936	220126	01.2209	230054	01.6021	230119	01.1895
210046	01.1195	220058	01.0118	220128	01.1053	230055	01.1451	230120	01.0485
210048	01.1631	220060	01.1394	220131	01.1600	230056	00.9740	230121	01.1978
210049	01.1574	220062	00.6459	220133	00.8163	230058	01.1574	230122	01.3594
210051	01.2987	220063	01.1314	220135	01.1216	230059	01.4275	230124	01.1282
210054	01.2530	220064	01.1833	220153	01.0615	230060	01.1550	230125	01.3778
210055	01.1864	220065	01.1802	220154	00.9829	230062	01.1155	230128	01.3803
210056	01.3710	220066	01.2842	220156	01.2133	230063	01.2606	230129	01.8959
210057	01.2377	220067	01.2460	220162	01.4154	230065	01.4452	230130	01.5703
210058	01.7027	220068	00.6142	220163	01.9473	230066	01.3047	230132	01.3326
210059	01.3246	220070	01.1430	220171	01.6249	230068	01.3382	230133	01.1317
210060	01.0387	220071	01.8364	220173	00.4926	230069	01.0842	230134	01.3096
220001	01.1455	220073	01.2169	220175	01.0281	230070	01.3124	230135	01.2971
220002	01.3339	220074	01.1303	220897	05.1063	230071	00.6451	230137	01.0688
220003	01.1052	220075	00.7598	220898	00.5184	230072	01.1754	230138	00.8920
220004	01.3526	220076	01.1903	220899	00.5200	230075	01.3006	230140	01.5311
220006	01.2667	220077	01.5935	230001	01.1380	230076	01.2008	230141	01.5159
220008	01.1517	220079	01.1113	230002	01.2264	230077	02.1412	230142	01.2211
220010	01.1987	220080	01.1914	230003	01.1340	230078	01.3494	230143	01.2287
220011	01.1745	220081	00.9630	230004	01.6977	230080	01.2457	230144	01.2039
220012	01.1783	220082	01.2163	230005	01.2082	230081	01.1805	230145	01.1011
220015	01.1955	220083	01.1173	230006	00.9902	230082	01.1693	230146	01.2209
220016	01.1822	220084	01.1402	230007	01.0874	230085	01.1510	230147	01.5170
220017	01.2453	220086	01.5508	230012	00.7936	230086	00.9502	230149	01.0323
220019	01.0963	220088	01.4854	230013	01.2781	230087	01.1035	230150	01.5858
220020	01.1486	220089	01.2671	230014	00.9354	230089	01.3413	230151	01.3966
220021	01.2272	220090	01.1744	230015	01.3998	230090	01.1216	230153	01.0639
220023	01.2625	220092	01.1877	230017	01.5254	230092	01.2605	230154	01.1036
220024	01.1928	220094	01.2019	230019	01.5578	230093	01.1906	230155	01.0427
220025	01.0177	220095	01.1789	230020	01.5718	230095	01.1450	230156	01.6121
220026	01.2698	220097	01.0091	230021	01.5158	230096	01.0844	230157	01.3851
220028	01.3958	220098	01.2938	230022	01.2618	230097	01.5015	230159	01.3519
220029	01.1196	220099	01.1297	230024	01.4667	230098	00.7519	230162	00.9358
220030	01.0752	220100	01.2618	230027	01.0804	230099	01.2163	230165	01.7048
220031	01.7694	220101	01.3756	230029	01.4894	230100	01.1905	230167	01.1934
220033	01.2295	220102	00.7887	230030	01.1748	230101	01.0476	230169	01.3184
220035	01.1757	220104	01.2410	230031	01.3672	230103	01.0029	230171	01.1818

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.

: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH DECEMBER 1991

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
230172	01.1439	230270	01.2648	240056	01.3087	240116	00.9400	240180	00.9663
230173	01.4271	230273	01.4385	240057	01.7572	240117	01.1208	240181	01.1108
230174	01.2172	230275	00.7450	240058	00.9789	240119	00.8942	240184	01.0888
230175	01.0197	230276	01.0169	240059	01.1062	240121	00.9326	240187	01.2038
230176	01.1364	230277	01.1445	240061	01.4214	240122	01.0927	240192	00.9223
230178	01.1632	230278	01.3676	240063	01.5108	240123	01.1280	240193	01.0907
230179	00.8224	230898	00.5183	240064	01.2170	240124	01.0059	240196	01.3415
230180	01.1261	230899	00.5200	240065	00.9885	240125	00.9411	240200	00.8882
230184	01.1551	240001	01.5525	240066	01.3442	240127	01.0744	240201	01.0099
230186	01.0102	240002	01.6772	240069	01.1868	240128	01.1689	240205	00.8630
230188	01.1156	240003	01.2518	240071	01.1145	240129	00.9582	240206	00.8691
230189	00.9079	240004	01.4701	240072	00.9980	240130	01.0139	240207	01.1578
230190	00.9770	240005	00.9336	240073	01.0056	240132	01.2876	240210	01.2426
230191	00.9704	240006	01.1714	240075	01.2335	240133	01.1273	240211	01.3121
230193	01.2994	240007	01.1036	240076	01.1225	240134	01.0280	240898	00.5196
230194	01.2165	240008	01.0298	240077	01.0165	240135	00.8382	240899	00.5200
230195	01.3539	240009	01.0648	240078	01.3835	240136	00.8750	250001	01.5232
230197	01.2297	240010	01.8442	240079	01.0763	240137	01.1870	250002	00.8101
230199	01.1807	240011	01.0432	240080	01.3625	240138	00.8505	250003	00.9667
230201	00.9735	240013	01.2242	240082	01.2115	240139	00.9802	250004	01.4368
230204	01.2434	240014	01.1907	240083	01.2346	240140	00.8291	250005	00.9593
230205	01.1088	240016	01.3556	240084	01.2279	240141	01.0038	250006	00.9742
230207	01.2858	240017	01.1897	240085	00.8600	240142	01.0587	250007	01.1598
230208	01.0809	240018	01.2133	240086	01.0710	240143	00.9457	250008	00.8814
230211	00.9528	240019	01.3203	240087	01.0587	240144	00.9873	250009	01.0987
230212	01.0831	240020	01.2205	240088	01.4423	240145	00.9044	250010	01.0838
230213	01.0755	240021	01.0521	240089	01.0096	240146	00.9948	250012	00.9682
230216	01.3168	240022	01.0970	240090	01.0258	240148	00.9883	250015	00.9488
230217	01.0783	240023	01.0387	240091	00.9892	240150	00.9497	250016	00.8825
230219	01.0066	240025	01.1940	240093	01.2884	240152	00.9568	250017	00.8838
230221	01.2415	240027	01.0591	240094	00.9901	240153	00.9323	250018	01.0221
230222	01.3525	240028	01.1189	240096	01.0569	240154	00.9760	250019	01.2674
230223	01.2882	240029	01.1722	240097	01.0456	240155	00.9647	250020	01.0198
230227	01.3220	240030	01.3210	240098	00.9286	240156	01.0383	250021	00.8865
230228	01.1907	240031	00.9693	240099	00.9673	240157	01.0822	250023	00.8288
230230	01.3387	240036	01.4856	240100	01.3045	240158	00.9253	250024	00.9312
230232	01.0412	240037	01.0452	240101	01.2128	240160	00.9687	250025	01.0173
230235	00.9852	240038	01.4651	240102	01.0642	240161	00.9851	250027	00.9818
230236	01.3334	240040	01.2753	240103	01.1615	240162	01.0598	250029	00.9028
230237	01.0843	240041	01.2215	240104	01.2225	240163	00.9841	250030	00.8954
230239	01.1589	240043	01.1198	240105	00.8976	240166	01.1833	250031	01.2566
230241	01.2039	240044	01.1645	240106	01.3231	240167	00.8225	250032	01.2148
230244	01.3639	240045	01.1042	240107	00.9717	240169	00.9676	250033	01.0404
230253	01.1020	240047	01.3852	240108	00.9372	240170	01.0514	250034	01.4456
230254	01.2612	240048	01.2586	240109	00.9743	240171	01.0879	250035	00.8393
230257	00.9134	240049	01.6408	240110	01.0183	240172	01.0974	250036	00.9640
230259	01.0826	240050	01.1178	240111	01.0075	240173	00.8721	250037	00.8906
230264	01.3921	240051	00.8773	240112	01.0110	240175	00.8058	250038	00.9200
230266	01.2378	240052	01.2165	240114	01.0988	240176	00.8777	250039	01.0136
230269	01.2346	240053	01.4558	240115	01.5158	240179	00.9654	250040	01.2040

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.

: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH DECEMBER 1991

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
250042	01.1247	250107	00.9221	260025	01.3034	260094	01.0703	260180	01.5535	260094	01.0703	260180	01.5535
250043	00.8894	250109	00.9893	260026	00.9651	260095	01.3633	260182	01.0287	260095	01.3633	260182	01.0287
250044	01.0552	250112	00.9511	260027	01.5425	260096	01.4339	260184	01.4370	260096	01.4339	260184	01.4370
250045	01.1668	250113	00.9415	260029	01.1546	260097	01.2057	260186	01.1359	260097	01.2057	260186	01.1359
250046	01.0486	250117	01.0837	260030	01.1216	260100	01.1322	260188	01.1762	260100	01.1322	260188	01.1762
250047	00.9340	250119	00.9708	260031	01.4522	260102	00.9714	260189	00.9424	260102	00.9714	260189	00.9424
250048	01.3314	250120	01.0690	260032	01.6089	260103	01.3151	260190	01.1455	260103	01.3151	260190	01.1455
250049	00.9234	250122	01.2673	260033	01.2708	260104	01.5977	260191	01.2650	260104	01.5977	260191	01.2650
250050	01.1677	250123	01.1464	260034	01.0357	260105	01.9034	260193	01.1966	260105	01.9034	260193	01.1966
250051	00.8826	250124	00.8807	260035	01.0585	260107	01.3031	260195	01.1117	260107	01.3031	260195	01.1117
250057	01.0908	250125	01.2574	260036	01.0804	260108	01.6492	260197	01.2138	260108	01.6492	260197	01.2138
250058	01.1705	250126	00.9941	260037	01.2423	260109	00.9965	260198	01.2956	260109	00.9965	260198	01.2956
250059	01.0072	250127	00.8579	260039	01.2908	260110	01.6325	260200	01.1599	260110	01.6325	260200	01.1599
250060	00.7996	250128	00.9747	260040	01.4929	260111	00.9736	260202	01.3720	260111	00.9736	260202	01.3720
250061	00.9222	250129	01.1868	260042	01.1057	260112	01.4293	260898	00.5196	260112	01.4293	260898	00.5196
250062	00.9936	250131	00.9698	260044	01.0713	260113	01.1681	260899	00.5200	260113	01.1681	260899	00.5200
250063	00.8533	250134	00.9456	260047	01.3360	260115	01.0318	270002	01.2270	260115	01.0318	270002	01.2270
250065	00.9489	250136	00.7368	260048	01.3619	260116	01.2017	270003	01.2098	260116	01.2017	270003	01.2098
250066	00.9400	250137	00.9566	260049	00.9763	260119	01.1452	270004	01.6612	260119	01.1452	270004	01.6612
250067	01.0130	250138	00.9143	260050	01.0855	260120	01.1723	270006	00.8631	260120	01.1723	270006	00.8631
250068	00.8491	250139	00.9025	260051	01.2067	260122	01.2244	270007	00.9852	260122	01.2244	270007	00.9852
250069	01.2286	250140	00.8086	260052	01.1861	260123	00.9744	270009	01.0743	260123	00.9744	270009	01.0743
250071	01.0417	250141	01.1842	260053	01.0727	260127	01.1439	270011	01.1330	260127	01.1439	270011	01.1330
250072	01.2247	250142	00.7975	260054	01.3405	260128	01.0267	270012	01.3864	260128	01.0267	270012	01.3864
250073	00.9908	250143	00.9179	260055	01.1987	260129	01.0761	270013	01.2741	260129	01.0761	270013	01.2741
250076	00.9144	250898	00.5196	260057	01.1632	260131	01.3532	270014	01.6195	260131	01.3532	270014	01.6195
250077	00.9350	250899	00.5200	260059	01.0663	260134	01.2830	270016	00.8960	260134	01.2830	270016	00.8960
250078	01.3812	260001	01.5577	260061	01.1121	260137	01.2215	270017	01.1889	260137	01.2215	270017	01.1889
250079	00.8564	260002	01.3321	260062	01.1662	260138	01.7838	270019	00.9810	260138	01.7838	270019	00.9810
250081	01.2362	260003	00.9550	260063	01.1717	260141	02.0284	270021	01.0869	260141	02.0284	270021	01.0869
250082	01.2527	260004	01.0372	260064	01.3788	260142	01.2001	270023	01.3085	260142	01.2001	270023	01.3085
250083	00.8969	260005	01.3762	260065	01.6091	260143	01.1463	270024	01.0474	260143	01.1463	270024	01.0474
250084	01.1993	260006	01.3910	260066	01.0367	260146	01.3530	270026	00.9351	260146	01.3530	270026	00.9351
250085	01.0011	260007	01.2516	260067	00.9155	260147	01.0368	270027	01.0342	260147	01.0368	270027	01.0342
250086	00.9265	260008	01.1950	260068	01.7711	260148	01.0130	270028	01.0321	260148	01.0130	270028	01.0321
250088	01.0125	260009	01.2595	260070	01.0648	260158	01.1349	270029	01.0902	260158	01.1349	270029	01.0902
250089	00.9991	260011	01.5395	260073	00.9690	260159	01.1081	270030	00.9306	260159	01.1081	270030	00.9306
250091	01.0209	260012	01.0014	260074	01.1946	260160	01.1247	270031	00.8980	260160	01.1247	270031	00.8980
250093	01.1545	260013	01.1559	260077	01.3789	260162	00.9993	270032	01.1308	260162	00.9993	270032	01.1308
250094	01.2687	260014	01.6183	260078	01.1076	260163	01.2092	270033	00.8281	260163	01.2092	270033	00.8281
250095	01.0474	260015	01.1773	260079	01.0051	260164	01.0634	270035	01.0465	260164	01.0634	270035	01.0465
250096	01.2004	260016	01.2397	260080	01.1189	260165	00.9847	270036	00.9939	260165	00.9847	270036	00.9939
250097	01.1793	260017	01.2127	260081	01.4034	260166	01.2306	270039	00.9223	260166	01.2306	270039	00.9223
250098	00.8454	260018	00.9508	260082	01.1552	260172	01.0171	270040	01.0091	260172	01.0171	270040	01.0091
250099	01.2073	260019	01.0171	260085	01.4329	260173	01.0752	270041	00.9219	260173	01.0752	270041	00.9219
250100	01.1534	260020	01.6072	260086	01.0521	260175	01.1399	270044	01.1112	260175	01.1399	270044	01.1112
250101	00.8876	260021	01.2811	260089	01.0811	260176	01.4735	270046	00.9506	260176	01.4735	270046	00.9506
250102	01.4386	260022	01.3859	260090	01.4633	260177	01.3011	270047	00.9894	260177	01.3011	270047	00.9894
250104	01.3161	260023	01.2742	260091	01.5472	260178	01.4137	270048	01.1184	260178	01.4137	270048	01.1184
250105	00.9118	260024	01.0645	260092	01.1313	260179	01.5396	270049	01.5723	260179	01.5396	270049	01.5723

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH DECEMBER 1991

PAGE 13 OF 23

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NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH DECEMBER 1991

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
310112	01.2250	320072	00.9134	330058	01.3208	330135	01.1965	330204	01.2380
310113	01.2184	320074	01.0652	330059	01.4801	330136	01.2481	330205	01.1031
310115	01.1824	320076	01.1177	330061	01.3001	330140	01.6347	330208	01.1778
310116	01.2458	320079	01.0741	330062	01.0854	330141	01.2493	330209	01.2043
310118	01.2034	320088	00.5182	330064	01.2793	330142	01.3154	330211	01.2315
310119	01.5134	320089	00.5200	330065	01.2031	330144	01.0114	330212	01.2419
310120	01.0530	330001	01.1573	330066	01.2180	330148	01.0180	330213	01.1492
310121	01.0509	330002	01.4178	330067	01.3155	330151	01.1101	330214	01.1432
310898	00.5196	330003	01.3324	330072	01.3231	330152	01.3930	330215	01.1806
310899	00.5200	330004	01.3470	330073	01.1239	330153	01.3069	330218	01.2610
320001	01.4284	330005	01.6610	330074	01.2555	330154	01.4019	330219	01.5511
320002	01.2439	330006	01.3761	330075	01.0668	330155	01.1711	330221	01.2897
320003	01.1377	330007	01.3450	330078	01.3561	330157	01.3175	330222	01.2118
320004	01.1801	330008	01.2121	330079	01.1011	330158	01.3176	330223	01.1131
320006	01.1917	330010	01.1917	330082	01.2226	330160	01.4422	330225	01.1777
320009	01.3541	330011	01.1983	330084	00.8693	330161	01.0632	330226	01.2953
320011	00.9576	330012	01.5868	330085	01.3317	330162	01.2347	330229	01.1835
320012	00.9723	330013	02.0354	330086	01.2771	330163	01.1747	330230	01.4634
320013	01.0935	330014	01.3753	330088	01.0898	330164	01.3840	330231	01.2070
320014	00.9425	330015	01.0378	330090	01.7305	330166	00.9395	330232	01.2588
320016	01.2059	330016	00.9929	330091	01.3645	330167	01.5236	330233	01.5082
320017	01.2024	330019	01.3490	330092	00.9851	330168	00.9973	330234	01.8912
320018	01.2379	330020	00.9973	330094	01.3163	330169	01.3720	330235	01.2159
320019	01.3548	330022	01.1030	330095	01.2609	330171	01.3071	330236	01.3588
320021	01.6425	330023	01.2037	330096	01.1434	330174	00.7840	330238	01.1054
320022	01.2351	330024	01.5899	330097	01.1778	330175	01.0509	330239	01.1781
320023	01.1024	330025	01.024	330100	00.6818	330176	00.8622	330240	01.3454
320030	01.0346	330027	01.4414	330101	01.6693	330177	01.0661	330241	01.7347
320031	00.9630	330028	01.3333	330102	01.2881	330179	00.9373	330242	01.2878
320032	00.9273	330029	01.1481	330103	01.1723	330180	01.2218	330244	01.0712
320033	01.0914	330030	01.1599	330104	01.3349	330181	01.2606	330245	01.3033
320035	01.0746	330033	01.1312	330106	01.5402	330182	02.2759	330246	01.1755
320037	01.2472	330034	01.0865	330107	01.2411	330183	01.4307	330247	00.6007
320038	01.2266	330036	01.1991	330108	01.2375	330184	01.2489	330249	01.2008
320046	01.0954	330037	01.0772	330110	01.1247	330185	01.1842	330250	01.2449
320048	01.2192	330038	01.1795	330111	01.1248	330186	01.0038	330252	00.9331
320056	00.9297	330039	00.9000	330114	00.9981	330188	01.2024	330254	00.9861
320057	01.0692	330041	01.3702	330115	01.2552	330189	00.8786	330258	01.3215
320058	00.8835	330043	01.2826	330116	01.0029	330191	01.2538	330259	01.3083
320059	01.0758	330044	01.2064	330118	01.5864	330193	01.3665	330261	01.2056
320060	00.9179	330045	01.3000	330119	01.5770	330194	01.7174	330263	01.0711
320061	01.2195	330046	01.5833	330121	01.0150	330195	01.6558	330264	01.2189
320062	00.8983	330047	01.2797	330122	01.2778	330196	01.3765	330265	01.2850
320063	01.2780	330048	01.2461	330125	01.7622	330197	01.0220	330267	01.2425
320065	01.1644	330049	01.3134	330126	01.2213	330198	01.3368	330268	01.1278
320067	00.8660	330053	01.0524	330127	01.2255	330199	01.2794	330269	01.8929
320068	00.8668	330055	01.3943	330128	01.3995	330201	01.5020	330270	01.1870
320069	01.0449	330056	01.4090	330132	01.1159	330202	01.2672	330275	01.2072
320070	00.9930	330057	01.5815	330133	01.2817	330203	01.4149	330276	01.1970

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.

: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH DECEMBER 1991

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991

PAGE 15 OF 23

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
330277	01.1660	330397	01.4297	340052	00.9654	340124	01.0989	350015	01.5061
330279	01.2536	330398	01.3045	340053	01.5704	340125	01.4481	350016	00.9585
330281	00.5865	330399	01.3740	340054	00.9833	340126	01.2820	350017	01.2579
330285	01.7031	330898	00.5184	340055	01.1548	340127	01.2081	350018	01.0418
330286	01.3267	330899	00.5200	340056	01.1856	340129	01.1142	350019	01.5266
330288	01.0133	340001	01.2404	340051	01.6078	340130	01.3899	350020	01.3499
330290	01.6685	340002	01.7820	340053	01.0115	340131	01.3413	350021	01.0395
330293	01.1313	340003	01.1435	340054	01.1032	340132	01.3657	350023	00.9263
330304	01.1989	340004	01.3954	340055	01.2402	340133	01.2113	350024	01.0001
330306	01.3801	340005	01.2246	340057	01.1056	340135	01.0416	350025	00.9635
330307	01.1486	340006	01.1648	340058	01.2634	340136	00.9614	350027	00.9697
330308	01.2473	340007	01.1116	340059	01.7376	340137	01.2062	350029	00.9776
330309	01.2655	340008	01.2217	340070	01.2945	340138	01.1089	350030	01.0582
330314	01.2773	340009	01.2648	340071	01.0871	340141	01.5315	350031	00.9810
330315	01.1910	340010	01.3128	340072	01.0476	340142	01.1637	350032	01.3053
330316	01.2799	340011	01.0781	340073	01.3482	340143	01.3666	350033	00.9688
330327	00.9488	340012	01.0743	340075	01.1893	340144	01.2602	350034	00.9727
330331	01.2008	340013	01.1872	340076	01.0244	340145	01.1953	350035	00.8449
330332	01.2653	340014	01.6284	340080	01.1014	340146	01.0203	350036	00.9076
330333	01.3150	340015	01.2257	340084	01.0221	340147	01.2785	350038	00.9526
330336	01.2640	340016	01.2028	340085	01.2491	340148	01.3089	350039	00.8935
330338	01.1580	340017	01.2031	340087	01.0862	340151	01.1634	350041	00.9930
330339	00.8648	340018	01.2122	340088	01.0764	340153	01.9198	350042	00.9265
330340	01.1330	340019	01.0662	340089	01.0124	340154	00.9284	350043	01.5744
330350	01.9215	340020	01.2519	340090	01.1315	340155	01.4968	350044	00.8569
330351	01.0933	340021	01.2154	340091	01.6586	340156	00.8534	350047	01.1519
330353	01.2130	340022	01.1558	340093	01.0479	340158	01.0492	350049	01.0615
330354	01.1772	340023	01.2726	340094	01.3398	340159	01.2119	350050	01.0010
330357	01.3776	340024	01.2260	340096	01.2097	340160	01.0407	350051	00.9505
330359	00.9417	340025	01.0940	340097	01.0062	340162	01.2649	350053	00.8922
330362	00.6534	340027	01.1217	340098	01.6183	340164	01.3377	350055	00.8727
330363	00.6845	340028	01.3877	340099	01.1457	340166	01.3225	350056	00.8603
330366	00.7261	340030	01.7523	340100	01.0956	340167	00.5762	350058	00.9942
330367	00.5681	340031	01.0756	340101	01.0643	340168	00.5300	350060	00.9168
330368	00.6233	340032	01.2943	340104	01.0020	340898	00.5196	350061	01.0142
330369	00.6711	340034	01.2779	340105	01.3302	340899	00.5200	350063	00.7953
330371	00.6549	340035	01.0914	340106	01.1064	350001	01.1026	350064	00.8623
330372	01.2421	340036	01.0860	340107	01.2896	350002	01.6352	350065	00.9920
330373	00.6816	340037	01.2507	340109	01.2934	350003	01.1400	350066	00.9984
330381	01.3074	340038	01.2043	340111	01.1799	350004	01.8644	350067	01.0656
330383	01.3691	340039	01.2345	340112	00.9991	350005	01.1970	350068	00.5196
330385	01.1783	340040	01.7078	340113	01.9433	350006	01.3887	350069	00.5200
330386	01.2131	340041	01.2337	340114	01.3841	350007	01.0270	350071	01.2226
330387	00.8627	340042	01.1508	340115	01.4469	350008	01.0426	350072	01.1431
330389	01.8356	340044	01.0107	340116	01.7276	350009	01.1669	350073	01.5658
330390	01.2295	340045	00.9733	340119	01.2190	350010	01.0820	350076	01.7152
330393	01.6495	340047	01.7790	340120	01.0632	350011	01.7312	350077	01.1430
330394	01.3833	340048	00.5900	340121	00.9440	350012	00.9732	350078	01.1916
330395	01.3378	340050	01.2034	340122	01.0351	350013	01.0990	350079	01.3037
330396	01.2310	340051	01.2232	340123	01.1902	350014	01.0561	350080	01.1657

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.

: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH DECEMBER 1991

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991

PAGE 16 OF 23

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
360011	01.2688	360067	01.1867	360123	01.1541	360185	01.1675
360012	01.2752	360068	01.4362	360124	01.2262	360186	01.1421
360013	01.0955	360069	01.0220	360125	01.0834	360187	01.3223
360014	01.1706	360070	01.3931	360126	01.2638	360188	00.9713
360015	01.4453	360071	01.2778	360127	01.0096	360189	01.0678
360016	01.4757	360072	01.1552	360128	01.0577	360192	01.2154
360017	01.7331	360074	01.3209	360129	01.0458	360193	01.2620
360018	01.3610	360075	01.4143	360130	01.0978	360194	01.0610
360019	01.1733	360076	01.2496	360131	01.2720	360195	01.1878
360020	01.2371	360077	01.4009	360132	01.1771	360197	01.1574
360021	01.2068	360078	01.2626	360133	01.3116	360200	01.2136
360024	01.2680	360079	01.6158	360134	01.5310	360203	01.1235
360025	01.2149	360080	01.2318	360135	01.1111	360204	01.1589
360026	01.1206	360081	01.3380	360136	01.0682	360210	01.1832
360027	01.4854	360082	01.3197	360137	01.5089	360211	01.1732
360028	01.3210	360083	01.2142	360139	01.1094	360212	01.4171
360029	01.1008	360084	01.4097	360140	01.0836	360218	01.3151
360030	01.1580	360085	01.6471	360141	01.4140	360230	01.2837
360031	01.2664	360086	01.3438	360142	00.9764	360231	01.1283
360032	01.1208	360087	01.3144	360143	01.2715	360232	01.1302
360034	01.0871	360088	01.1562	360144	01.2875	360234	01.2226
360035	01.4566	360089	01.1092	360145	01.4933	360236	01.2094
360036	01.1737	360090	01.1715	360147	01.2190	360238	00.8448
360037	01.8243	360091	01.3100	360148	01.1922	360239	01.2025
360038	01.4361	360092	01.1705	360149	01.0874	360240	00.5388
360039	01.2386	360093	01.1582	360150	01.2049	360241	00.6501
360040	01.2696	360094	01.2112	360151	01.2795	360242	01.5486
360041	01.2336	360095	01.2971	360152	01.4982	360243	00.8675
360042	01.0928	360096	01.1068	360153	01.1558	360244	00.5184
360044	01.0952	360098	01.3126	360154	01.0467	360245	00.5200
360045	01.5106	360099	01.0472	360155	01.2083	360246	00.9081
360046	01.1347	360100	01.2812	360156	01.1294	360247	01.1848
360047	01.1163	360101	01.6002	360159	01.1421	360248	01.1247
360048	01.7040	360102	01.2254	360161	01.2217	360249	01.0062
360049	01.2535	360103	01.3331	360162	01.2163	360250	01.0033
360050	01.2657	360104	00.8994	360163	01.6517	360251	00.9691
360051	01.4826	360106	01.1571	360164	00.9676	360254	01.1094
360052	01.5898	360107	01.2097	360165	01.0692	360255	01.2691
360053	01.1928	360108	01.0245	360166	01.0386	360256	01.5444
360054	01.1928	360109	01.0346	360169	01.0041	360257	00.9236
360055	01.2931	360112	01.5994	360170	01.1506	360258	00.9518
360056	01.9648	360113	01.2367	360171	01.3331	360259	00.9993
360057	00.9648	360114	01.0518	360172	01.1534	360260	00.9983
360058	01.0899	360115	01.2371	360174	01.1481	360261	00.8518
360059	01.4730	360116	01.0292	360175	01.1481	360262	00.8918
360061	01.0460	360118	01.2455	360176	01.1409	360263	01.1807
360062	01.6356	360119	01.2274	360177	01.2651	360264	01.0963
360063	01.0518	360120	00.7106	360178	01.2657	360265	01.2445
360064	01.4481	360121	01.1784	360179	01.2516	360266	01.5312
360065	01.1965	360122	01.2276	360180	02.1048	360267	01.0342
360066	01.2309	360123	01.2276	360184	00.7063	360268	01.6203

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH DECEMBER 1991

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS

CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH DECEMBER 1991

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
390145	01.2077	390200	01.0849	390899	00.5200	400114	01.0792	420039	01.1107
390146	01.1874	390201	01.3200	400001	01.1881	400115	01.0219	420040	01.3040
390147	01.1797	390203	01.2850	400002	01.2619	400117	01.1646	420042	01.0843
390148	01.1450	390204	01.2733	400003	01.1298	400118	01.1589	420043	01.1479
390149	01.2549	390205	01.2314	400004	01.1206	400120	01.3046	420044	01.1473
390150	01.2004	390206	01.2467	400005	01.1140	400121	01.0225	420048	01.1359
390151	01.2469	390209	00.9586	400006	01.1571	400898	00.5196	420049	01.0901
390152	01.0106	390211	01.1450	400007	01.0914	400899	00.5200	420051	01.5358
390153	01.2124	390213	01.0178	400008	01.1094	410001	01.2630	420053	01.1017
390154	01.1162	390215	01.1778	400009	00.9779	410002	01.2355	420054	01.1395
390155	01.2803	390217	01.1410	400010	00.9458	410004	01.4273	420055	01.0400
390156	01.3738	390219	01.1903	400011	01.1151	410005	01.2999	420056	01.0084
390157	01.1784	390220	01.1172	400012	01.0291	410006	01.1826	420057	01.0795
390158	01.2512	390222	01.1946	400013	01.0254	410007	01.5217	420059	01.0485
390159	01.3086	390223	01.5740	400014	01.3307	410008	01.2004	420061	01.2556
390160	01.1731	390224	00.9522	400015	01.0703	410009	01.3363	420062	01.2827
390161	01.0764	390225	01.2679	400016	01.2595	410010	01.0407	420064	01.0795
390162	01.2337	390226	01.6080	400017	01.1041	410011	01.1912	420065	01.3002
390163	01.1978	390228	01.1861	400018	01.2617	410012	01.5811	420066	01.0041
390164	01.8624	390229	01.4254	400019	01.3508	410013	01.1469	420067	01.1186
390165	01.0746	390231	01.3033	400021	01.2994	410898	00.5196	420068	01.1797
390166	01.1072	390232	01.0853	400022	01.2823	410899	00.5200	420069	01.0023
390167	01.2338	390233	01.2849	400024	01.0325	420002	01.3240	420070	01.2608
390168	01.1900	390235	01.8288	400026	00.9313	420004	01.9427	420071	01.3698
390169	01.2273	390236	01.1930	400027	01.0911	420005	01.1073	420072	00.9958
390170	01.6154	390237	01.4891	400028	01.0395	420006	01.5351	420073	01.2805
390171	01.0817	390238	01.0094	400029	01.0170	420007	01.4119	420074	00.9684
390172	01.1806	390242	01.2194	400031	01.0524	420009	01.2345	420075	01.0698
390173	01.1219	390244	00.8730	400032	01.1264	420010	01.0809	420076	01.2665
390174	01.5807	390245	01.3427	400037	00.5692	420011	01.0845	420078	01.5720
390176	01.2013	390246	01.2164	400038	00.9750	420014	01.1106	420079	01.5496
390178	01.3262	390247	01.1041	400044	01.2408	420015	01.2475	420080	01.1496
390179	01.2269	390249	00.9808	400048	01.1459	420016	01.2167	420081	00.7876
390180	01.3859	390252	00.9369	400061	01.7371	420018	01.6236	420082	01.3718
390181	01.0733	390256	01.6516	400079	01.1457	420019	01.1733	420083	01.1968
390183	01.1363	390258	01.2932	400087	01.2501	420020	01.1773	420084	00.8455
390184	01.1014	390260	01.2395	400088	00.7437	420022	00.9983	420085	01.2552
390185	01.1590	390261	01.8236	400089	01.0861	420023	01.2449	420086	01.3713
390186	01.1075	390262	01.6794	400094	00.9166	420026	01.8136	420087	01.5173
390187	01.1026	390263	01.4378	400098	01.2250	420027	01.3422	420088	01.1821
390189	01.1099	390265	01.2528	400102	01.0973	420028	01.0602	420089	01.2615
390191	01.0642	390266	01.1168	400103	01.4186	420029	01.8435	420098	00.5313
390192	01.0709	390267	01.2177	400104	01.2728	420030	01.1602	420099	00.5200
390193	01.1893	390268	01.2218	400105	01.2768	420031	00.9776	430004	01.0589
390194	01.0999	390270	01.2963	400106	01.1445	420032	00.8787	430005	01.3206
390195	01.5444	390272	00.6242	400109	01.4987	420033	01.1668	430007	01.1418
390196	01.2926	390275	00.5310	400110	01.1753	420035	00.8405	430008	01.2122
390197	01.2815	390277	01.6310	400111	01.2148	420036	01.2587	430009	01.0996
390198	01.2482	390278	00.8910	400112	01.2234	420037	01.2765	430010	01.0968
390199	01.2215	390898	00.5192	400113	01.1732	420038	01.2094	430011	01.3505

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH DECEMBER 1991

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991

PAGE 19 OF 23

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
430012	01.3084	430087	01.0579	440063	01.4083	440149	01.1562	450016	01.6544
430013	01.2454	430088	00.9421	440064	01.0954	440150	01.2932	450018	01.6503
430014	01.1890	440001	00.9710	440065	01.1440	440151	01.1714	450019	02.8940
430015	01.0293	440002	01.5655	440067	01.1697	440152	01.5694	450020	01.0557
430016	01.6953	440003	01.1090	440068	01.1621	440153	00.9806	450021	01.7629
430017	01.0848	440006	01.3970	440069	01.0935	440154	00.7147	450023	01.4166
430018	00.9456	440007	01.0231	440070	00.9308	440156	01.4041	450024	01.2536
430022	00.9458	440008	00.9625	440071	01.3170	440157	01.0081	450025	01.4466
430023	00.9379	440009	01.0308	440072	01.3583	440159	01.2140	450027	01.1954
430024	01.0137	440010	00.9318	440073	01.2856	440160	01.0405	450028	01.4483
430025	01.0095	440011	01.2254	440074	00.8608	440161	01.5762	450029	01.3719
430026	00.8553	440012	01.3384	440078	01.0116	440162	01.0043	450031	01.1900
430027	01.6561	440014	00.8858	440079	00.8498	440166	01.2763	450032	01.2096
430028	01.1055	440015	01.4816	440081	01.1415	440168	01.0281	450033	01.6006
430029	00.9983	440016	00.9602	440082	01.8158	440170	01.3334	450034	01.4963
430031	00.9975	440017	01.4762	440083	01.2483	440173	01.4729	450035	01.4695
430033	00.9929	440018	01.2990	440084	01.0829	440174	00.9087	450037	01.4597
430034	01.0588	440019	01.4703	440087	01.0207	440175	01.1848	450039	01.1511
430036	01.0453	440020	01.2235	440090	01.0366	440176	01.2756	450040	01.6108
430037	00.9834	440022	01.0825	440095	01.3860	440177	00.9367	450041	00.9472
430038	01.0461	440023	00.9773	440098	01.0953	440178	01.1921	450042	01.6229
430039	01.0090	440024	01.1467	440100	01.0999	440180	01.0819	450043	01.4104
430040	00.9203	440025	01.1475	440102	01.0618	440181	00.9828	450044	01.4927
430041	00.9454	440026	01.2751	440103	01.2865	440182	00.9364	450046	01.3798
430042	00.9998	440029	01.2259	440104	01.4334	440183	01.4240	450047	00.9998
430043	01.1914	440030	01.0524	440105	01.3087	440184	01.2448	450050	01.2859
430044	00.9388	440031	01.0529	440109	01.0568	440185	01.0517	450051	01.6291
430047	01.0810	440032	00.9562	440110	01.0801	440186	01.1522	450052	01.0289
430048	01.1315	440033	01.0851	440111	01.2744	440187	01.0761	450053	01.1015
430049	00.9209	440034	01.3879	440114	01.0018	440189	01.4806	450054	01.6246
430051	00.8773	440035	01.1765	440115	01.1553	440192	00.8532	450055	01.0724
430054	00.9451	440038	00.9218	440120	01.4563	440193	01.0727	450056	01.6171
430056	00.8748	440039	01.5765	440121	01.0677	440194	01.2600	450057	01.1806
430057	00.9685	440040	00.9040	440125	01.4404	440196	00.9973	450058	01.5082
430060	00.9537	440041	00.8864	440128	00.9216	440197	01.3314	450059	01.2849
430062	00.8516	440046	01.0325	440130	01.1082	440200	01.0815	450060	01.3500
430064	01.0446	440047	00.9206	440131	01.1177	440203	00.9772	450063	00.8432
430065	00.9423	440048	01.5953	440132	01.0465	440205	00.9808	450064	01.4579
430066	01.0643	440049	01.6157	440133	01.4522	440208	00.5197	450065	01.1445
430073	01.1110	440050	01.1505	440135	01.3828	440209	00.5200	450068	01.6470
430076	01.0211	440051	00.9205	440136	01.2873	450002	01.3864	450070	01.1262
430077	01.4148	440052	01.1596	440138	01.0608	450004	01.0625	450072	01.1843
430079	01.0445	440053	01.1735	440141	00.9095	450005	01.0307	450073	01.1778
430080	00.8204	440054	00.9849	440142	01.0573	450007	01.3619	450074	01.1898
430081	01.0074	440056	00.9662	440143	01.0382	450008	01.2329	450076	01.2329
430082	00.8879	440057	00.9621	440144	01.1350	450010	01.2689	450077	00.9726
430083	00.8287	440058	01.1529	440145	00.9853	450011	01.5573	450078	00.9892
430084	01.0482	440059	01.1398	440146	01.3775	450012	01.2168	450079	01.4361
430085	00.9199	440060	01.2190	440147	00.7335	450014	01.1106	450080	01.1779
430086	00.8609	440061	01.1074	440148	01.1368	450015	01.5125	450081	01.1803

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH DECEMBER 1991

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
450082	00.9878	450155	01.0332	450237	01.5126	450355	01.0741	450489	01.0442
450083	01.5443	450157	01.0099	450239	01.1959	450358	01.9532	450497	01.1356
450085	00.9962	450160	01.0575	450241	00.9517	450362	00.9684	450498	01.0658
450087	01.3390	450162	01.3390	450243	00.9273	450365	00.9715	450508	01.4049
450090	01.1553	450163	01.1193	450246	00.9979	450366	01.6461	450514	01.1396
450092	01.2944	450164	00.9439	450249	00.9346	450369	01.1674	450517	00.9377
450094	01.3856	450165	00.9336	450253	01.0849	450370	01.1883	450518	01.3356
450096	01.4924	450166	00.8618	450258	01.1207	450371	01.1062	450523	01.4825
450097	01.4141	450169	00.8653	450259	01.2308	450372	01.3072	450530	01.3099
450098	01.1252	450170	01.0904	450264	00.8503	450373	01.1546	450534	00.9543
450099	01.2202	450175	01.1666	450268	01.2098	450374	00.8612	450535	01.2194
450101	01.3902	450176	01.2832	450269	00.9470	450376	01.4562	450537	01.3913
450102	01.6896	450177	01.0842	450270	01.1608	450378	01.2775	450538	01.2977
450104	01.2474	450178	01.0815	450271	01.1922	450379	01.5759	450539	01.2685
450107	01.4183	450179	01.0164	450272	01.3403	450381	00.8646	450544	01.2497
450108	00.9694	450181	00.9942	450276	00.9661	450388	01.6205	450545	01.1671
450109	00.9858	450183	00.9973	450278	00.9057	450389	01.2353	450546	01.3580
450110	01.2155	450184	01.4658	450280	01.3054	450393	01.2800	450547	00.9746
450111	01.1778	450185	01.0386	450283	01.1518	450395	01.0896	450550	01.0319
450112	01.2127	450187	01.1771	450286	01.0898	450399	01.0396	450551	01.0391
450113	01.2878	450188	00.9746	450288	01.1503	450400	01.0660	450557	01.0538
450115	01.0680	450190	01.2664	450289	01.3791	450403	01.2092	450558	01.7882
450118	01.4149	450191	01.1072	450292	01.2671	450410	01.0659	450559	00.8825
450119	01.2371	450192	01.0919	450293	00.9699	450411	01.0600	450561	01.5047
450121	01.3651	450193	02.1479	450296	01.2220	450417	01.0292	450563	01.2059
450123	01.0641	450194	01.1301	450297	01.0674	450418	01.3690	450565	01.2924
450124	01.4506	450195	01.4354	450299	01.3529	450419	01.2510	450570	01.0008
450126	01.3166	450196	01.2475	450303	00.9489	450422	00.7494	450571	01.4405
450127	01.0078	450197	01.2008	450306	01.0477	450423	01.3512	450573	01.0363
450128	01.1509	450200	01.2921	450307	00.9572	450424	01.2682	450574	01.0282
450130	01.4644	450201	00.9786	450309	01.0480	450429	00.9324	450575	00.9963
450131	01.2453	450203	01.1729	450315	01.2300	450431	01.4965	450578	00.9630
450132	01.4508	450207	01.0764	450320	01.2982	450438	01.0520	450580	01.1800
450133	01.4421	450209	01.3398	450321	00.8811	450446	00.8813	450583	01.0112
450135	01.5677	450211	01.2090	450322	00.9304	450447	01.2796	450584	01.1850
450137	01.3428	450212	01.2599	450324	01.5257	450450	01.0934	450586	01.1113
450140	00.9070	450213	01.4222	450325	01.1884	450451	01.0167	450587	01.2652
450142	01.2794	450214	01.3077	450327	00.9930	450457	01.6592	450591	01.2213
450143	01.0147	450217	00.8757	450330	01.0889	450460	00.9727	450596	01.2305
450144	01.1266	450218	00.9962	450334	01.0785	450462	01.5850	450597	01.0431
450145	00.9544	450219	01.1150	450337	01.1784	450464	00.9097	450603	00.9690
450146	01.0182	450221	00.9934	450340	01.3527	450465	01.1069	450604	01.2344
450147	01.3537	450222	01.6862	450341	00.9360	450467	01.0530	450605	01.2340
450148	01.3152	450224	01.1254	450346	01.3103	450469	01.2746	450607	00.8981
450149	01.4288	450229	01.3541	450347	01.2278	450473	01.0949	450609	00.8539
450150	01.0242	450231	01.5950	450348	00.9811	450475	01.1409	450610	01.3881
450151	01.0793	450233	01.0909	450349	01.1467	450476	01.0202	450614	01.0266
450152	01.4122	450234	00.9314	450351	01.2655	450484	01.5207	450615	00.9538
450153	01.5918	450235	01.0319	450352	01.2257	450485	00.9499	450617	01.3736
450154	01.1277	450236	01.1188	450353	01.1381	450488	01.2127	450620	01.0614

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.

: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH DECEMBER 1991

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991

PAGE 21 OF 23

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
450623	01.1476	450697	01.4699	450770	00.9889	470005	01.1979	490048	01.3388
450626	00.9551	450698	00.9552	450771	01.4111	470006	01.2789	490047	01.1653
450628	00.9503	450700	00.9175	450773	01.1124	470008	01.2208	490048	01.3225
450630	01.6511	450702	01.2760	450775	01.1776	470010	01.0254	490050	01.3135
450631	01.6362	450703	01.2785	450898	00.5185	470011	01.1556	490052	01.4038
450632	00.9847	450704	01.2962	450899	00.5200	470012	01.2596	490053	01.2112
450633	01.5711	450705	00.8149	460001	01.5910	470013	01.1287	490054	01.0658
450634	01.3409	450706	01.2481	460003	01.4113	470015	01.2089	490057	01.3419
450637	01.3098	450709	01.1947	460004	01.7064	470018	01.1678	490059	01.4007
450638	01.4733	450711	01.6225	460005	01.2454	470020	01.0005	490060	01.0770
450639	01.5158	450712	00.7194	460006	01.3458	470023	01.2311	490063	01.5852
450641	00.8841	450713	01.2517	460007	01.3776	470024	01.1076	490066	01.1116
450643	01.1766	450715	01.3764	460008	01.3143	490001	01.1323	490067	01.2715
450644	01.6030	450716	01.2263	460009	01.7483	490002	01.0317	490069	01.3486
450646	01.4840	450717	01.2375	460010	01.9660	490003	00.6395	490071	01.2856
450647	01.9827	450718	01.1224	460011	01.3179	490004	01.2101	490073	01.2196
450648	01.1252	450723	01.2326	460013	01.4278	490005	01.4001	490074	01.2449
450649	01.0717	450724	01.1880	460014	01.0621	490006	01.1376	490075	01.2375
450651	01.8189	450725	00.9321	460015	01.2529	490007	01.9148	490077	01.1729
450652	00.9919	450726	00.8599	460016	00.9745	490008	01.1116	490079	01.2313
450653	01.2314	450727	00.9686	460017	01.2250	490009	01.6351	490083	00.7805
450654	00.9789	450728	00.9472	460018	00.9533	490010	01.1770	490084	01.1388
450656	01.2664	450729	00.9489	460019	01.0058	490011	01.2872	490085	01.2258
450658	00.9588	450730	01.4028	460020	00.9427	490012	01.0014	490088	01.1191
450659	01.4433	450732	01.1608	460021	01.2977	490013	01.1187	490089	01.0411
450660	01.6517	450733	01.3195	460022	00.9521	490014	01.5709	490090	01.1363
450661	01.2154	450734	01.2375	460023	01.1429	490015	01.4681	490091	01.1587
450662	01.4387	450735	00.8265	460024	01.0117	490017	01.2780	490092	01.1211
450665	00.9758	450737	00.8791	460025	00.8553	490018	01.0867	490093	01.2491
450666	01.2175	450742	01.3395	460026	00.9581	490019	01.1426	490094	01.0887
450668	01.5190	450743	01.4476	460027	00.9403	490020	01.0785	490095	01.2782
450669	01.3242	450745	00.8077	460029	00.9543	490021	01.3897	490097	01.1425
450670	01.2277	450746	00.9051	460030	01.0972	490022	01.2225	490098	01.2686
450672	01.5931	450747	01.3162	460032	00.9703	490023	01.1895	490099	00.9336
450673	01.0182	450749	01.0372	460033	00.9858	490024	01.6477	490100	01.2993
450674	00.8367	450750	00.9804	460035	00.9104	490027	01.0316	490101	01.1101
450675	01.3391	450751	01.3373	460036	00.9599	490028	01.2898	490104	00.8736
450677	01.3364	450753	00.9048	460037	00.9599	490030	01.3082	490105	00.7261
450678	01.4938	450754	00.8722	460039	00.9527	490031	01.0667	490106	00.7954
450681	01.5216	450755	01.0120	460041	01.2414	490032	01.6436	490107	01.2615
450682	01.2870	450757	00.9510	460042	01.3789	490033	01.2261	490108	00.8624
450683	01.3102	450758	01.4096	460043	01.2982	490035	01.2400	490109	00.8145
450684	01.3007	450759	01.1331	460044	01.1330	490037	01.1340	490110	01.2088
450685	01.2243	450760	01.3684	460046	00.9837	490038	01.2384	490111	01.1740
450686	01.3796	450761	00.9382	460047	01.6108	490040	01.3770	490112	01.5107
450688	01.3271	450763	01.0496	460048	00.5196	490041	01.1789	490113	01.2435
450690	01.3170	450765	01.0945	460049	00.5200	490042	01.2832	490114	01.0200
450691	01.1673	450766	01.6135	470001	01.1564	490043	01.1755	490115	01.1474
450694	01.2216	450768	01.0823	470003	01.9130	490044	01.2678	490116	01.1893
450696	01.0664	450769	00.9555	470004	01.1646	490045	01.1589	490117	01.0684

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.

: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH DECEMBER 1991

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
490118	01.7073	500051	01.6277	500127	01.0519	510058	01.2105	520034	01.1832
490119	01.3397	500052	01.2199	500129	01.6358	510059	01.4222	520035	01.2521
490120	01.3092	500053	01.2526	500132	00.8248	510060	01.1601	520037	01.5960
490122	01.2075	500054	01.8276	500134	00.7403	510061	01.0490	520038	01.2987
490123	01.1363	500055	00.9629	500135	01.1288	510062	01.1464	520039	01.0154
490124	01.2094	500057	01.2672	500137	00.8291	510063	01.0619	520040	01.4174
490126	01.1955	500058	01.3159	500138	07.0911	510065	00.9937	520041	01.1147
490127	01.0650	500059	01.1346	500139	01.3462	510066	01.1450	520042	01.0127
490129	01.1401	500060	01.1839	500140	01.0335	510067	01.2778	520044	01.3333
490130	01.2281	500061	01.1698	500141	01.2346	510068	01.1025	520045	01.6380
490131	00.9497	500062	00.9586	500143	00.6451	510070	01.1906	520047	00.9704
490898	00.5185	500064	01.5577	500898	00.5185	510071	01.2567	520048	01.3229
490899	00.5200	500065	01.2726	500899	00.5200	510072	01.0244	520049	01.8077
500001	01.3037	500068	01.1644	510001	01.6416	510076	00.9725	520051	02.0414
500002	01.4095	500069	01.0012	510002	01.2824	510077	01.1417	520053	01.0585
500003	01.2861	500071	01.4032	510004	00.9408	510080	00.9917	520054	01.1941
500005	01.7196	500072	01.1949	510005	00.9523	510081	01.0073	520056	01.2993
500007	01.3095	500073	00.9418	510006	01.2044	510082	01.0169	520057	01.1415
500008	01.8947	500074	01.1165	510007	01.3741	510084	00.9481	520058	01.1071
500009	01.3186	500075	01.1767	510008	01.1726	510085	01.2046	520059	01.2641
500011	01.2218	500076	01.3138	510009	01.0303	510086	01.0422	520060	01.2323
500012	01.4964	500077	01.2247	510012	01.0428	510087	00.7675	520062	01.1789
500014	01.6630	500078	01.2940	510013	01.1459	520002	01.2749	520063	01.1924
500015	01.2843	500079	01.2506	510015	00.9063	520003	01.1504	520064	01.5197
500016	01.3652	500080	00.9168	510016	01.0076	520004	01.2442	520066	01.2357
500019	01.2405	500084	01.0035	510018	01.1304	520006	01.0229	520068	01.0682
500021	01.3708	500085	01.0518	510020	01.0968	520007	01.0810	520069	01.1981
500023	01.1643	500086	01.3255	510022	01.6247	520008	01.2004	520070	01.3171
500024	01.3348	500088	01.3065	510023	01.0375	520009	01.4757	520071	01.1762
500025	01.9312	500089	01.0160	510024	01.3137	520010	01.0967	520074	01.1135
500026	01.2537	500090	00.9145	510025	00.9025	520011	01.0892	520075	01.3924
500027	01.5794	500092	01.0780	510026	00.9758	520012	00.9264	520076	01.1606
500028	00.9881	500093	01.1705	510027	01.0050	520013	01.2887	520077	01.0289
500029	00.8975	500094	00.9211	510028	01.0652	520014	01.1740	520078	01.3122
500030	01.3448	500096	01.0582	510029	01.2433	520015	01.1644	520081	01.2238
500031	01.2319	500097	01.1723	510030	01.1212	520016	00.9844	520082	01.2813
500033	01.1501	500098	00.8613	510031	01.2711	520017	01.1666	520083	01.4987
500034	00.9200	500101	00.8910	510033	01.2111	520018	00.9703	520084	01.0795
500035	01.3931	500102	00.9656	510035	01.0599	520019	01.2357	520087	01.4852
500036	01.2762	500104	01.2425	510036	01.1241	520021	01.1840	520088	01.2179
500037	01.1511	500106	00.8918	510038	01.0047	520024	00.9820	520089	01.4068
500039	01.2991	500107	01.0965	510039	01.2755	520025	01.1231	520090	01.1483
500041	01.2065	500108	01.6490	510040	00.9642	520026	01.0953	520091	01.2251
500042	01.3023	500110	01.2181	510043	00.9995	520027	01.1398	520092	01.1655
500043	01.1726	500118	01.1796	510046	01.2532	520028	01.3876	520094	01.1628
500044	01.9039	500119	01.2504	510047	01.1249	520029	00.9306	520095	01.3054
500045	01.1537	500122	01.2079	510048	01.1308	520030	01.5238	520096	01.4423
500048	00.9342	500123	01.0362	510050	01.2260	520031	01.1646	520097	01.2966
500049	01.2301	500124	01.3282	510053	01.0018	520032	01.1415	520098	01.6714
500050	01.2771	500125	00.9528	510055	01.1619	520033	01.2564	520100	01.2286

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.

: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH DECEMBER 1991

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991

PAGE 23 OF 23

PROVIDER CASE MIX	PROVIDER CASE MIX	PROVIDER CASE MIX	PROVIDER CASE MIX
520101 01.1672	520177 01.5263		
520102 01.1975	520178 01.1647		
520103 01.3449	520180 00.6036		
520104 00.9950	520898 00.5196		
520107 01.2338	520899 00.5200		
520109 01.0785	530001 01.2428		
520110 00.9839	530002 01.1366		
520111 01.0896	530003 00.9530		
520112 01.1200	530004 00.9961		
520113 01.2130	530005 01.0865		
520114 01.0570	530006 01.0919		
520115 01.2976	530007 01.0376		
520116 01.1964	530008 01.1465		
520117 01.0751	530009 00.9901		
520118 00.9407	530010 01.2515		
520120 01.0842	530011 01.1264		
520121 00.9647	530012 01.6027		
520122 01.0401	530014 01.1252		
520123 01.0392	530015 01.1345		
520124 01.1529	530016 01.1563		
520130 01.0705	530017 00.9896		
520131 01.0713	530018 01.0646		
520132 01.1558	530019 00.9882		
520134 01.1471	530022 01.1225		
520135 01.0616	530023 00.9090		
520136 01.4677	530024 00.9669		
520138 01.8363	530025 01.2490		
520139 01.1935	530026 01.0612		
520140 01.4028	530027 00.8697		
520141 01.0957	530029 00.9020		
520142 00.9897	530031 00.9951		
520144 01.0093	530032 01.2519		
520145 01.0206	530898 00.5183		
520146 01.1614			
520148 01.1000			
520149 01.0489			
520151 01.0610			
520152 01.1404			
520153 01.0141			
520154 01.1121			
520156 01.0848			
520157 01.0066			
520159 00.9077			
520160 01.7466			
520161 01.0675			
520170 01.3002			
520171 00.9938			
520173 01.0598			
520174 01.4641			
520176 00.8365			

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH DECEMBER 1991

BILLING CODE 4120-01-C

TABLE 4a.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS

[Areas that Qualify as Large Urban Areas Are Designated with an Asterisk]

Urban area (constituent counties or county equivalents)	Wage index	GAF
Abilene, TX.....	0.9429	0.9605
Taylor, TX.....		
Aguadilla, PR.....	0.4568	0.5848
Aquada, PR.....		
Aguadilla, PR.....		
Isabella, PR.....		
Moca, PR.....		
Akron, OH.....	0.8921	0.9248
Portage, OH.....		
Summit, OH.....		
Albany, GA.....	0.8050	0.8620
Dougherty, GA.....		
Lee, GA.....		
Albany-Schenectady-Troy, NY...	0.8956	0.9273
Albany, NY.....		
Greene, NY.....		
Montgomery, NY.....		
Rensselaer, NY.....		
Saratoga, NY.....		
Schenectady, NY.....		
Albuquerque, NM.....	1.0123	1.0084
Bernalillo, NM.....		
Alexandria, LA.....	0.8275	0.8784
Rapides, LA.....		
Allentown-Bethlehem-Easton, PA-NJ.....	0.8797	0.9160
Warren, NJ.....		
Carbon, PA.....		
Lehigh, PA.....		
Northampton, PA.....		
Altoona, PA.....	0.9238	0.9472
Blair, PA.....		
Amarillo, TX.....	0.8739	0.9118
Potter, TX.....		
Randall, TX.....		
*Anaheim-Santa Ana, CA.....	1.1756	1.1172
Orange, CA.....		
Anchorage, AK.....	1.4176	1.2699
Anchorage, AK.....		
Anderson, IN.....	0.9583	0.9713
Madison, IN.....		
Anderson, SC.....	0.7258	0.8029
Anderson, SC.....		
Ann Arbor, MI.....	1.1384	1.0928
Washtenaw, MI.....		
Anniston, AL.....	0.7931	0.8532
Calhoun, AL.....		
Appleton-Oshkosh-Neenah, WI.....	0.9223	0.9461
Calumet, WI.....		
Outagamie, WI.....		
Winnebago, WI.....		
Arecibo, PR.....	0.3953	0.5296
Arecibo, PR.....		
Camuy, PR.....		
Hatillo, PR.....		
Quebradillas, PR.....		
Asheville, NC.....	0.8739	0.9118
Buncombe, NC.....		
Athens, GA.....	0.7773	0.8415
Clarke, GA.....		
Jackson, GA.....		
Madison, GA.....		
Oconee, GA.....		
*Atlanta, GA.....	0.9596	0.9722

TABLE 4a.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

[Areas that Qualify as Large Urban Areas Are Designated with an Asterisk]

Urban area (constituent counties or county equivalents)	Wage index	GAF
Barrow, GA.....		
Butts, GA.....		
Cherokee, GA.....		
Clayton, GA.....		
Cobb, GA.....		
Coweta, GA.....		
De Kalb, GA.....		
Douglas, GA.....		
Fayette, GA.....		
Forsyth, GA.....		
Fulton, GA.....		
Gwinnett, GA.....		
Henry, GA.....		
Newton, GA.....		
Paulding, GA.....		
Rockdale, GA.....		
Spalding, GA.....		
Walton, GA.....		
Atlantic City, NJ.....	1.0609	1.0413
Atlantic City, NJ.....		
Cape May, NJ.....		
Augusta, GA-SC.....	0.9401	0.9586
Columbia, GA.....		
McDuffie, GA.....		
Richmond, GA.....		
Aiken, SC.....		
Aurora-Elgin, IL.....	0.9463	0.9629
Kane, IL.....		
Kendall, IL.....		
Austin, TX.....	0.9599	0.9724
Hays, TX.....		
Travis, TX.....		
Williamson, TX.....		
Bakersfield, CA.....	1.0868	1.0587
Kern, CA.....		
*Baltimore, MD.....	1.0156	1.0107
Anne Arundel, MD.....		
Baltimore, MD.....		
Baltimore City, MD.....		
Carroll, MD.....		
Harford, MD.....		
Howard, MD.....		
Queen Annes, MD.....		
Bangor, ME.....	0.9064	0.9349
Penobscot, ME.....		
Baton Rouge, LA.....	0.9089	0.9367
Ascension, LA.....		
East Baton Rouge, LA.....		
Livingston, LA.....		
West Baton Rouge, LA.....		
Battle Creek, MI.....	0.9099	0.9374
Calhoun, MI.....		
Beaumont-Port Arthur, TX.....	0.9604	0.9727
Hardin, TX.....		
Jefferson, TX.....		
Orange, TX.....		
Beaver County, PA.....	1.0165	1.0113
Beaver, PA.....		
Bellingham, WA.....	1.0497	1.0338
Whatcom, WA.....		
Benton Harbor, MI.....	0.8091	0.8650
Berrien, MI.....		
*Bergen-Passaic, NJ.....	0.8565	0.8994
Bergen, NJ.....		
Passaic, NJ.....		
Billings, MT.....	0.9325	0.9533
Yellowstone, MT.....		
Biloxi-Gulfport, MS.....	0.8062	0.8628
Hancock, MS.....		
Harrison, MS.....		
Binghamton, NY.....	0.9260	0.9487

TABLE 4a.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

[Areas that Qualify as Large Urban Areas Are Designated with an Asterisk]

Urban area (constituent counties or county equivalents)	Wage index	GAF
Broome, NY.....		
Tioga, NY.....		
Birmingham, AL.....	0.8769	0.9140
Blount, AL.....		
Jefferson, AL.....		
Saint Clair, AL.....		
Shelby, AL.....		
Walker, AL.....		
Bismarck, ND.....	0.8881	0.9219
Burleigh, ND.....		
Morton, ND.....		
Bloomington, IN.....	0.7757	0.8404
Monroe, IN.....		
Bloomington-Normal, IL.....	0.8658	0.9060
McLean, IL.....		
Boise City, ID.....	0.9757	0.9833
Ada, ID.....		
*Boston-Lawrence-Salem-Lowell-Brockton, MA.....	1.1809	1.1206
Essex, MA.....		
Middlesex, MA.....		
Norfolk, MA.....		
Plymouth, MA.....		
Suffolk, MA.....		
Boulder-Longmont, CO.....	0.9689	0.9786
Boulder, CO.....		
Bradenton, FL.....	0.8730	0.9112
Manatee, FL.....		
Brazoria, TX.....	0.8947	0.9266
Brazoria, TX.....		
Bremerton, WA.....	1.0365	1.0249
Kitsap, WA.....		
Bridgeport-Stamford-Norwalk-Danbury, CT.....	1.1905	1.1268
Fairfield, CT.....		
Brownsville-Harlingen, TX.....	0.8601	0.9019
Cameron, TX.....		
Bryan-College Station, TX.....	0.9489	0.9647
Brazos, TX.....		
Buffalo, NY.....	0.8908	0.9239
Erie, NY.....		
Burlington, NC.....	0.7936	0.8536
Alamance, NC.....		
Burlington, VT.....	0.9358	0.9556
Chittenden, VT.....		
Grand Isle, VT.....		
Caguas, PR.....	0.4588	0.5865
Caguas, PR.....		
Gurabo, PR.....		
San Lorenzo, PR.....		
Agua Buenas, PR.....		
Cayey, PR.....		
Cidra, PR.....		
Canton, OH.....	0.8453	0.8913
Carroll, OH.....		
Stark, OH.....		
Casper, WY.....	0.8891	0.9227
Natrona, WY.....		
Cedar Rapids, IA.....	0.7532	0.8236
Linn, IA.....		
Champaign-Urbana-Rantoul, IL.....	0.8745	0.9123
Champaign, IL.....		
Charleston, SC.....	0.8331	0.8825
Berkeley, SC.....		
Charleston, SC.....		
Dorchester, SC.....		
Charleston, WV.....	0.9692	0.9788
Kanawha, WV.....		
Putnam, WV.....		
*Charlotte-Gastonia-Rock Hill, NC-SC.....	0.9486	0.9645

TABLE 4a.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

[Areas that Qualify as Large Urban Areas Are Designated with an Asterisk]

Urban area (constituent counties or county equivalents)	Wage index	GAF
Cabarrus, NC		
Gaston, NC		
Lincoln, NC		
Mecklenburg, NC		
Rowan, NC		
Union, NC		
York, SC		
Charlottesville, VA	0.9615	0.9735
Albermarle, VA		
Charlottesville City, VA		
Fluvanna, VA		
Greene, VA		
Chattanooga, TN-GA	0.9198	0.9444
Catoosa, GA		
Dade, GA		
Walker, GA		
Hamilton, TN		
Marion, TN		
Sequatchie, TN		
Cheyenne, WY	0.7777	0.8418
Laramie, WY		
*Chicago, IL	1.0518	1.0352
Cook, IL		
Du Page, IL		
McHenry, IL		
Chico, CA	1.0981	1.0662
Butte, CA		
*Cincinnati, OH-KY-IN	0.0921	0.9877
Dearborn, IN		
Boone, KY		
Campbell, KY		
Kenton, KY		
Clermont, OH		
Hamilton, OH		
Warren, OH		
Clarksville-Hopkinsville, TN-KY	0.7319	0.8076
Christian, KY		
Montgomery, TN		
*Cleveland, OH	1.0739	1.0500
Cuyahoga, OH		
Geauga, OH		
Lake, OH		
Medina, OH		
Colorado Springs, CO	0.9816	0.9874
El Paso, CO		
Columbia, MO	0.9506	0.9659
Boone, MO		
Columbia, SC	0.8940	0.9281
Lexington, SC		
Richland, SC		
Columbus, GA-AL	0.7371	0.8115
Russell, AL		
Chattanooga, GA		
Muscogee, GA		
*Columbus, OH	0.9673	0.9775
Delaware, OH		
Fairfield, OH		
Franklin, OH		
Licking, OH		
Madison, OH		
Pickaway, OH		
Union, OH		
Corpus Christi, TX	0.8594	0.9014
Neuces, TX		
San Patricio, TX		
Cumberland, MD-WV	0.8188	0.8721
Allegany, MD		
Mineral, WV		
*Dallas, TX	0.9638	0.9751

TABLE 4a.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

[Areas that Qualify as Large Urban Areas Are Designated with an Asterisk]

Urban area (constituent counties or county equivalents)	Wage index	GAF
Collins, TX		
Dallas, TX		
Denton, TX		
Ellis, TX		
Kaufman, TX		
Rockwall, TX		
Danville, VA	0.7826	0.8455
Danville City, VA		
Pittsylvania, VA		
Davenport-Rock Island-Moline, IA-IL	0.8471	0.8926
Scott, IA		
Henry, IL		
Rock Island, IL		
Dayton-Springfield, OH	0.9646	0.9756
Clark, OH		
Greene, OH		
Miami, OH		
Montgomery, OH		
Daytona Beach, FL	0.8906	0.9237
Volusia, FL		
Decatur, AL	0.7487	0.8202
Lawrence, AL		
Morgen, AL		
Decatur, IL	0.8286	0.8792
Macon, IL		
*Denver, CO	1.0762	1.0516
Adams, CO		
Arapahoe, CO		
Denver, CO		
Douglas, CO		
Jefferson, CO		
Des Moines, IA	0.9171	0.9425
Dallas, IA		
Polk, IA		
Warren, IA		
*Detroit, MI	1.0827	1.0559
Lapeer, MI		
Livingston, MI		
Macomb, MI		
Monroe, MI		
Oakland, MI		
Saint Clair, MI		
Wayne, MI		
Dothan, AL	0.7569	0.8264
Dale, AL		
Houston, AL		
Dubuque, IA	0.8374	0.8856
Dubuque, IA		
Duluth, MN-WI	0.9517	0.9667
St. Louis, MN		
Douglas, WI		
Eau Claire, WI	0.8481	0.8933
Chippewa, WI		
Eau Claire, WI		
El Paso, TX	0.8714	0.9100
El Paso, TX		
Elkhart-Goshen, IN	0.8872	0.9213
Elkhart, IN		
Elmira, NY	0.8852	0.9199
Chemung, NY		
Enid, OK	0.8912	0.9242
Garfield, OK		
Erie, PA	0.9155	0.9413
Erie, PA		
Eugene-Springfield, OR	1.0164	1.0112
Lane, OR		
Evansville, IN-KY	0.9276	0.9498
Posey, IN		
Vanderburgh, IN		
Warrick, IN		
Henderson, KY		
Fargo-Moorhead, ND-MN	0.9707	0.9798

TABLE 4a.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

[Areas that Qualify as Large Urban Areas Are Designated with an Asterisk]

Urban area (constituent counties or county equivalents)	Wage index	GAF
Clay, MN		
Cass, ND		
Fayetteville, NC	0.8296	0.8799
Cumberland, NC		
Fayetteville-Springdale, AR	0.7990	0.8576
Washington, AR		
Flint, MI	1.1544	1.1033
Genesee, MI		
Florence, AL	0.7717	0.8374
Colbert, AL		
Lauderdale, AL		
Florence, SC	0.8429	0.8896
Florence, SC		
Fort Collins-Loveland, CO	1.0238	1.0162
Larimer, CO		
*Fort Lauderdale-Hollywood-Pompano Beach, FL	1.0356	1.0242
Lee, FL		
Fort Myers-Cape Coral, FL	0.9799	0.9862
Martin, FL		
Fort Pierce, FL	1.1041	1.0702
Martin, FL		
St. Lucie, FL		
Fort Smith, AR-OK	0.7931	0.8532
Crawford, AR		
Sebastian, AR		
Sequoyah, OK		
Fort Walton Beach, FL	0.8941	0.9262
Okaloosa, FL		
Fort Wayne, IN	0.8901	0.934
Allen, IN		
De Kalb, IN		
Whitley, IN		
*Fort Worth-Arlington, TX	0.9747	0.9826
Johnson, TX		
Parker, TX		
Tarrant, TX		
Fresno, CA	1.0737	1.0499
Fresno, CA		
Gadsden, AL	0.8199	0.8729
Etowah, AL		
Gainesville, FL	0.8798	0.9160
Alachua, FL		
Bradford, FL		
Galveston-Texas City, TX	0.9428	0.9605
Galveston, TX		
Gary-Hammond, IN	0.9596	0.9722
Lake, IN		
Porter, IN		
Glens Falls, NY	0.9231	0.9467
Warren, NY		
Washington, NY		
Grand Forks, ND	0.9577	0.9708
Grand Forks, ND		
Grand Rapids, MI	0.9883	0.9920
Kent, MI		
Ottawa, MI		
Great Falls, MT	0.9092	0.9995
Cascade, MT		
Greeley, CO	0.9358	0.9556
Weld, CO		
Green Bay, WI	0.9585	0.9714
Brown, WI		
Greensboro-Winston-Salem-High Point, NC	0.9165	0.9120
Davidson, NC		
Davie, NC		
Forsyth, NC		
Guilford, NC		
Randolph, NC		
Stokes, NC		
Yadkin, NC		
Greenville-Spartanburg, SC	0.8923	0.9249

TABLE 4a.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

[Areas that Qualify as Large Urban Areas Are Designated with an Asterisk]

Urban area (constituent counties or county equivalents)	Wage index	GAF
Greenville, SC		
Pickens, SC		
Spartanburg, SC		
Hagerstown, MD	0.9157	0.9415
Washington, MD		
Hamilton-Middletown, OH	0.9153	0.9412
Butler, OH		
Harrisburg-Lebanon-Carlisle, PA	0.9919	0.9944
Cumberland, PA		
Dauphin, PA		
Lebanon, PA		
Perry, PA		
*Hartford-Middletown-New Britain-Bristol, CT	1.1910	1.1272
Hartford, CT		
Litchfield, CT		
Middlesex, CT		
Tolland, CT		
Hickory, NC	0.8666	0.9066
Alexander, NC		
Burke, NC		
Catawba, NC		
Honolulu, HI	1.1580	1.1057
Honolulu, HI		
Houma-Thibodaux, LA	0.7344	0.8095
Lafourche, LA		
Terrebonne, LA		
*Houston, TX	0.9935	0.9955
Fort Bend, TX		
Harris, TX		
Liberty, TX		
Montgomery, TX		
Waller, TX		
Huntington-Ashland, WV-KY-OH	0.9438	0.9612
Boyd, KY		
Carter, KY		
Greenup, KY		
Lawrence, OH		
Cabell, WV		
Wayne, WV		
Huntsville, AL	0.8835	0.9187
Madison, AL		
*Indianapolis, IN	0.9663	0.9768
Boone, IN		
Hamilton, IN		
Hancock, IN		
Hendricks, IN		
Johnson, IN		
Marion, IN		
Morgan, IN		
Shelby, IN		
Iowa City, IA	0.9528	0.9674
Johnson, IA		
Jackson, MI	0.8826	0.9180
Jackson, MI		
Jackson, MS	0.7733	0.8386
Hinds, MS		
Madison, MS		
Rankin, MS		
Jackson, TN	0.8329	0.8823
Madison, TN		
Jacksonville, FL	0.9051	0.9340
Clay, FL		
Duval, FL		
Nassau, FL		
St. Johns, FL		
Jacksonville, NC	0.7936	0.8536
Onslow, NC		
Jamestown-Dunkirk, NY	0.6634	0.7550
Chautauque, NY		
Janesville-Beloit, WI	0.8447	0.8909

TABLE 4a.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

[Areas that Qualify as Large Urban Areas Are Designated with an Asterisk]

Urban area (constituent counties or county equivalents)	Wage index	GAF
Rock, WI		
Jersey City, NJ	1.1276	1.0857
Hudson, NJ		
Johnson City-Kingsport-Bristol, TN-VA	0.8668	0.9067
Carter, TN		
Hawkins, TN		
Sullivan, TN		
Unicoi, TN		
Washington, TN		
Bristol City, VA		
Scott, VA		
Washington, VA		
Johnstown, PA	0.8613	0.9028
Cambria, PA		
Somerset, PA		
Joliet, IL	1.0509	1.0346
Grundy, IL		
Will, IL		
Joplin, MO	0.7957	0.8551
Jasper, MO		
Newton, MO		
Kalamazoo, MI	1.1709	1.1141
Kalamazoo, MI		
Kankakee, IL	0.8489	0.8939
Kankakee, IL		
*Kansas City, KS-MO	0.9588	0.9716
Johnson, KS		
Leavenworth, KS		
Miami, KS		
Wyandotte, KS		
Cass, MO		
Clay, MO		
Jackson, MO		
Lafayette, MO		
Platte, MO		
Ray, MO		
Kenosha, WI	0.8855	0.9201
Kenosha, WI		
Killeen-Temple, TX	1.1295	1.0870
Bell, TX		
Coryell, TX		
Knoxville, TN	0.8693	0.9065
Anderson, TN		
Blount, TN		
Grainger, TN		
Jefferson, TN		
Knox, TN		
Sevier, TN		
Union, TN		
Kokomo, IN	0.9603	0.9726
Howard, IN		
Tipton, IN		
LaCrosse, WI	0.8956	0.9273
LaCrosse, WI		
Lafayette, LA	0.8227	0.8749
Lafayette, LA		
St. Martin, LA		
Lafayette, IN	0.8432	0.8898
Tipppecanoe, IN		
Lake Charles, LA	0.8374	0.8856
Calcasieu, LA		
Lake County, IL	0.9408	0.9591
Lake, IL		
Lakeland-Winter Haven, FL	0.7659	0.8331
Polk, FL		
Lancaster, PA	0.9278	0.9500
Lancaster, PA		
Lansing-East Lansing, MI	1.0222	1.0151
Clinton, MI		
Eaton, MI		
Ingham, MI		
Laredo, TX	0.7278	0.8045

TABLE 4a.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

[Areas that Qualify as Large Urban Areas Are Designated with an Asterisk]

Urban area (constituent counties or county equivalents)	Wage index	GAF
Webb, TX		
Las Cruces, NM	0.7909	0.8516
Dona Ana, NM		
Las Vegas, NV	1.0631	1.0428
Clark, NV		
Lawrence, KS	0.7504	0.8215
Douglas, KS		
Lawton, OK	0.8388	0.8866
Comanche, OK		
Lewiston-Auburn, ME	0.8457	0.8916
Androscoggin, ME		
Lexington-Fayette, KY	0.8446	0.8908
Bourbon, KY		
Clark, KY		
Fayette, KY		
Jessamine, KY		
Scott, KY		
Woodford, KY		
Lima, OH	0.8453	0.8913
Allen, OH		
Auglaize, OH		
Lincoln, NE	0.8956	0.9273
Lancaster, NE		
Little Rock-North Little Rock, AR	0.8420	0.8889
Faulkner, AR		
Lonoke, AR		
Pulaski, AR		
Saline, AR		
Longview-Marshall, TX	0.8691	0.9084
Gregg, TX		
Harrison, TX		
Lorain-Elyria, OH	0.8896	0.9230
Lorain, OH		
*Los Angeles-Long Beach, CA	1.2359	1.1561
Los Angeles, CA		
Louisville, KY-IN	0.9092	0.9369
Clark, IN		
Floyd, IN		
Harrison, IN		
Bullitt, KY		
Jefferson, KY		
Oldham, KY		
Shelby, KY		
Lubbock, TX	0.8790	0.9155
Lubbock, TX		
Lynchburg, VA	0.8544	0.8978
Amherst, VA		
Campbell, VA		
Lynchburg City, VA		
Macon-Warner Robins, GA	0.8804	0.9165
Bibb, GA		
Houston, GA		
Jones, GA		
Peach, GA		
Madison, WI	1.0311	1.0212
Dane, WI		
Manchester-Nashua, NH	1.0130	1.0089
Hillsborough, NH		
Merrimack, NH		
Mansfield, OH	0.8392	0.8869
Richland, OH		
Mayaguez, PR	0.4771	0.6024
Anasco, PR		
Cabo Rojo, PR		
Hormigueros, PR		
Mayaguez, PR		
San German, PR		
McAllen-Edinburg-Mission, TX	0.7715	0.8372
Hidalgo, TX		
Medford, OR	1.0045	1.0031
Jackson, OR		
Melbourne-Titusville, FL	0.8730	0.9112

TABLE 4a.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

[Areas that Qualify as Large Urban Areas Are Designated with an Asterisk]

Urban area (constituent counties or county equivalents)	Wage index	GAF
Brevard, FL		
Memphis, TN-AR-MS	0.9060	0.9346
Crittenden, AR		
De Soto, MS		
Shelby, TN		
Tipton, TN		
Merced, CA	1.0315	1.0215
Merced, CA		
*Miami-Hialeah, FL	0.9955	0.9969
Dade, FL		
*Middlesex-Somerset-		
Hunterdon, NJ	1.0409	1.0278
Hunterdon, NJ		
Middlesex, NJ		
Somerset, NJ		
Midland, TX	1.0377	1.0257
Midland, TX		
*Milwaukee, WI	0.9719	0.9807
Milwaukee, WI		
Ozaukee, WI		
Washington, WI		
Waukesha, WI		
*Minneapolis-St. Paul, MN-WI	1.0818	1.0553
Anoka, MN		
Carver, MN		
Chisago, MN		
Dakota, MN		
Hennepin, MN		
Isanti, MN		
Ramsey, MN		
Scott, MN		
Washington, MN		
Wright, MN		
St. Croix, WI		
Mobile, AL	0.8244	0.8761
Baldwin, AL		
Mobile, AL		
Modesto, CA	1.1388	1.0931
Stanislaus, CA		
Monmouth-Ocean, NJ	0.9912	0.9940
Monmouth, NJ		
Ocean, NJ		
Monroe, LA	0.7664	0.8483
Ouachita, LA		
Montgomery, AL	0.7738	0.8389
Autauga, AL		
Elmore, AL		
Montgomery, AL		
Muncie, IN	0.8068	0.8633
Delaware, IN		
Muskegon, MI	0.9853	0.9899
Muskegon, MI		
Naples, FL	1.0324	1.0221
Collier, FL		
Nashville, TN	0.9397	0.9583
Cheatham, TN		
Davidson, TN		
Dickson, TN		
Robertson, TN		
Rutherford, TN		
Sumner, TN		
Williamson, TN		
Wilson, TN		
*Nassau-Suffolk, NY	1.2154	1.1429
Nassau, NY		
Suffolk, NY		
New Bedford-Fall River-Attle-		
boro, MA	1.1713	1.1144
Bristol, MA		
New Haven-Waterbury-Meriden,		
CT	1.2095	1.1391
New Haven, CT		
New London-Norwich, CT	1.1571	1.1051

TABLE 4a.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

[Areas that Qualify as Large Urban Areas Are Designated with an Asterisk]

Urban area (constituent counties or county equivalents)	Wage index	GAF
New London, CT		
*New Orleans, LA	0.8908	0.9239
Jefferson, LA		
Orleans, LA		
St. Bernard, LA		
St. Charles, LA		
St. John The Baptist, LA		
St. Tammany, LA		
*New York, NY	1.3460	1.2257
Bronx, NY		
Kings, NY		
New York City, NY		
Putnam, NY		
Queens, NY		
Richmond, NY		
Rockland, NY		
Westchester, NY		
*Newark, NJ	1.0906	1.0612
Essex, NJ		
Morris, NJ		
Sussex, NJ		
Union, NJ		
Niagara Falls, NY	0.7560	0.8257
Niagara, NY		
*Norfolk-Virginia Beach-New-		
port News, VA	0.8515	0.8958
Chesapeake City, VA		
Gloucester, VA		
Hampton City, VA		
James City Co., VA		
Newport News City, VA		
Norfolk City, VA		
Poquoson, VA		
Portsmouth City, VA		
Suffolk City, VA		
Virginia Beach City, VA		
Williamsburg City, VA		
York, VA		
*Oakland, CA	1.4529	1.2915
Alameda, CA		
Contra Costa, CA		
Ocala, FL	0.8614	0.9029
Marion, FL		
Odessa, TX	1.0839	1.0567
Ector, TX		
Oklahoma City, OK	0.9145	0.9406
Canadian, OK		
Cleveland, OK		
Logan, OK		
McClain, OK		
Oklahoma, OK		
Pottawatomie, OK		
Olympia, WA	1.1002	1.0676
Thurston, WA		
Omaha, NE-IA	0.8889	0.9296
Pottawattamie, IA		
Douglas, NE		
Sarpy, NE		
Washington, NE		
Orange County, NY	1.0121	1.0083
Orange, NY		
*Orlando, FL	0.9621	0.9739
Orange, FL		
Osceola, FL		
Seminole, FL		
Owensboro, KY	0.8151	0.8694
Daviess, KY		
Oxnard-Ventura, CA	1.1792	1.1195
Ventura, CA		
Panama City, FL	0.8632	0.9042
Bay, FL		
Parkersburg-Marietta, WV-OH	0.8540	0.8976

TABLE 4a.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

[Areas that Qualify as Large Urban Areas Are Designated with an Asterisk]

Urban area (constituent counties or county equivalents)	Wage index	GAF
Washington, OH		
Wood, WV		
Pascagoula, MS	0.8771	0.9141
Jackson, MS		
Pensacola, FL	0.8623	0.9035
Escambia, FL		
Santa Rosa, FL		
Peoria, IL	0.8710	0.9098
Peoria, IL		
Tazewell, IL		
Woodford, IL		
*Philadelphia, PA-NJ	1.0952	1.0643
Burlington, NJ		
Camden, NJ		
Gloucester, NJ		
Bucks, PA		
Chester, PA		
Delaware, PA		
Montgomery, PA		
Philadelphia, PA		
*Phoenix, AZ	1.0429	1.0292
Maricopa, AZ		
Pine Bluff, AR	0.6979	0.7817
Jefferson, AR		
*Pittsburgh, PA	1.0127	1.0087
Allegheny, PA		
Fayette, PA		
Washington, PA		
Westmoreland, PA		
Pittsfield, MA	1.0782	1.0529
Berkshire, MA		
Ponce, PR	0.4601	0.5877
Juana Diaz, PR		
Ponce, PR		
*Portland, ME	0.9257	0.9485
Cumberland, ME		
Sagadahoc, ME		
York, ME		
*Portland, OR	1.1576	1.1054
Clackamas, OR		
Multnomah, OR		
Washington, OR		
Yamhill, OR		
Portsmouth-Dover-Rochester,		
NH	1.0027	1.0018
Rockingham, NH		
Strafford, NH		
Poughkeepsie, NY	0.9369	0.9563
Dutchess, NY		
*Providence-Pawtucket-		
Woonsocket, RI	1.0380	1.0259
Bristol, RI		
Kent, RI		
Newport, RI		
Providence, RI		
Washington, RI		
Provo-Orem, UT	1.0230	1.0157
Utah, UT		
Pueblo, CO	0.8722	0.9106
Pueblo, CO		
Racine, WI	0.8488	0.8938
Racine, WI		
Raleigh-Durham, NC	0.9465	0.9630
Durham, NC		
Franklin, NC		
Orange, NC		
Wake, NC		
Rapid City, SD	0.8400	0.8875
Pennington, SD		
Reading, PA	1.0271	1.0185
Berks, PA		
Redding, CA	1.0549	1.0373

TABLE 4a.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

[Areas that Qualify as Large Urban Areas Are Designated with an Asterisk]

Urban area (constituent counties or county equivalents)	Wage index	GAF
Shasta, CA		
Reno, NV	1.1618	1.1082
Washoe, NV		
Richland-Kennewick, WA	0.9402	0.9587
Benton, WA		
Franklin, WA		
Richmond-Petersburg, VA	0.9417	0.9597
Charles City Co., VA		
Chesterfield, VA		
Colonial Heights City, VA		
Dinwiddie, VA		
Goochland, VA		
Hanover, VA		
Henrico, VA		
Hopewell City, VA		
New Kent, VA		
Petersburg City, VA		
Powhatan, VA		
Prince George, VA		
Richmond City, VA		
*Riverside-San Bernardino, CA	1.1107	1.0745
Riverside, CA		
San Bernardino, CA		
Roanoke, VA	0.8284	0.8790
Botetourt, VA		
Roanoke, VA		
Roanoke City, VA		
Salem City, VA		
Rochester, MN	1.1030	1.0694
Olmsted, MN		
*Rochester, NY	0.9710	0.9800
Livingston, NY		
Monroe, NY		
Ontario, NY		
Orleans, NY		
Wayne, NY		
Rockford, IL	0.9283	0.9503
Boone, IL		
Winnebago, IL		
*Sacramento, CA	1.2253	1.1493
Eldorado, CA		
Placer, CA		
Sacramento, CA		
Yolo, CA		
Saginaw-Bay City-Midland, MI	1.0484	1.0329
Bay, MI		
Midland, MI		
Saginaw, MI		
St. Cloud, MN	0.8919	0.9246
Benton, MN		
Sherburne, MN		
Stearns, MN		
St. Joseph, MO	0.9414	0.9595
Buchanan, MO		
*St. Louis, MO-IL	0.9388	0.9577
Clinton, IL		
Jersey, IL		
Madison, IL		
Monroe, IL		
St. Clair, IL		
Franklin, MO		
Jefferson, MO		
St. Charles, MO		
St. Louis, MO		
St. Louis City, MO		
Salem, OR	0.9837	0.9888
Marion, OR		
Polk, OR		
Salinas-Seaside-Monterey, CA	1.3041	1.1994
Monterey, CA		
*Salt Lake City-Ogden, UT	0.9932	0.9953

TABLE 4a.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

[Areas that Qualify as Large Urban Areas Are Designated with an Asterisk]

Urban area (constituent counties or county equivalents)	Wage index	GAF
Davis, UT		
Salt Lake, UT		
Weber, UT		
San Angelo, TX	0.8139	0.8665
Tom Green, TX		
*San Antonio, TX	0.8452	0.8912
Bexar, TX		
Comal, TX		
Guadalupe, TX		
*San Diego, CA	1.1934	1.1287
San Diego, CA		
*San Francisco, CA	1.4447	1.2865
Marin, CA		
San Francisco, CA		
San Mateo, CA		
*San Jose, CA	1.4900	1.3140
Santa Clara, CA		
*San Juan, PR	0.4987	0.6210
Barcelona, PR		
Bayamon, PR		
Canovanas, PR		
Carolina, PR		
Catano, PR		
Corozal, PR		
Dorado, PR		
Fajardo, PR		
Florida, PR		
Guaynabo, PR		
Humacao, PR		
Juncos, PR		
Los Piedras, PR		
Loiza, PR		
Lugaillo, PR		
Manati, PR		
Naranjito, PR		
Rio Grande, PR		
San Juan, PR		
Toa Alta, PR		
Toa Baja, PR		
Troje Alto, PR		
Vega Alta, PR		
Vega Baja, PR		
Santa Barbara-Santa Maria-Lompoc, CA	1.1805	1.1203
Santa Barbara, CA		
Santa Cruz, CA	1.1818	1.1212
Santa Cruz, CA		
Santa Fe, NM	0.9162	0.9418
Los Alamos, NM		
Santa Fe, NM		
Santa Rosa-Petaluma, CA	1.2957	1.1941
Sonoma, CA		
Sarasota, FL	0.9781	0.9850
Sarasota, FL		
Savannah, GA	0.8327	0.8822
Chatham, GA		
Eaffingham, GA		
Scranton-Wilkes Barre, PA	0.8959	0.9275
Columbia, PA		
Lackawanna, PA		
Luzerne, PA		
Monroe, PA		
Wyoming, PA		
*Seattle, WA	1.0871	1.0589
King, WA		
Snohomish, WA		
Sharon, PA	0.8914	0.9243
Mercer, PA		
Sheboygan, WI	0.8872	0.9213
Sheboygan, WI		
Sherman-Denison, TX	0.9089	0.9367
Grayson, TX		
Shreveport, LA	0.9299	0.9514

TABLE 4a.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

[Areas that Qualify as Large Urban Areas Are Designated with an Asterisk]

Urban area (constituent counties or county equivalents)	Wage index	GAF
Bossier, LA		
Caddo, LA		
Sioux City, IA-NE	0.8504	0.8950
Woodbury, IA		
Dakota, NE		
Sioux Falls, SD	0.8833	0.9185
Minnehaha, SD		
South Bend-Mishawaka, IN	1.0067	1.0046
St. Joseph, IN		
Spokane, WA	1.0691	1.0468
Spokane, WA		
Springfield, IL	0.9295	0.9512
Menard, IL		
Sangamon, IL		
Springfield, MO	0.8082	0.8643
Christian, MO		
Greene, MO		
Springfield, MA	0.9589	0.9717
Hampden, MA		
Hampshire, MA		
State College, PA	0.9901	0.9932
Centre, PA		
Steubenville-Weirton, OH-WV	0.8712	0.9099
Jefferson, OH		
Brooke, WV		
Hancock, WV		
Stockton, CA	1.1789	1.1193
San Joaquin, CA		
Syracuse, NY	0.9917	0.9943
Madison, NY		
Onondaga, NY		
Oswego, NY		
Tacoma, WA	0.9868	0.9909
Pierce, WA		
Tallahassee, FL	0.9220	0.9459
Gadsden, FL		
Leon, FL		
*Tampa-St. Petersburg-Clearwater, FL	0.9188	0.9437
Hernando, FL		
Hillsborough, FL		
Pasco, FL		
Pinellas, FL		
Terre Haute, IN	0.8758	0.9132
Clay, IN		
Vigo, IN		
Texarkana-TX-Texarkana, AR	0.7906	0.8514
Miller, AR		
Bowie, TX		
Toledo, OH	0.8714	0.9100
Fulton, OH		
Lucas, OH		
Wood, OH		
Topeka, KS	0.9302	0.9517
Shawnee, KS		
Trenton, NJ	1.0038	1.0026
Mercer, NJ		
Tucson, AZ	0.9620	0.9738
Pima, AZ		
Tulsa, OK	0.8532	0.8970
Creeks, OK		
Osage, OK		
Rogers, OK		
Tulsa, OK		
Wagoner, OK		
Tuscaloosa, AL	0.8521	0.8962
Tuscaloosa, AL		
Tyler, TX	0.9838	0.9889
Smith, TX		
Utica-Rome, NY	0.8402	0.8876
Herkimer, NY		
Oneida, NY		
Vallejo-Fairfield-Napa, CA	1.2917	1.1916

TABLE 4a.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

[Areas that Qualify as Large Urban Areas Are Designated with an Asterisk]

Urban area (constituent counties or county equivalents)	Wage index	GAF
Napa, CA		
Salano, CA		
Vancouver, WA	1.0712	1.0482
Clark, WA		
Victoria, TX	0.8994	0.9300
Victoria, TX		
Vineland-Millville-Bridgeton, NJ	0.9649	0.9758
Cumberland, NJ		
Visalia-Tulare-Porterville, CA	1.0392	1.0267
Tulare, CA		
Waco, TX	0.7814	0.8446
McLennan, TX		
*Washington, DC-MD-VA	1.0941	1.0635
District of Columbia, DC		
Calvert, MD		
Charles, MD		
Frederick, MD		
Montgomery, MD		
Prince Georges, MD		
Alexandria City, VA		
Arlington, VA		
Fairfax, VA		
Fairfax City, VA		
Falls Church City, VA		
Loudoun, VA		
Manassas City, VA		
Manassas Park City, VA		
Prince William, VA		
Stafford, VA		
Waterloo-Cedar Falls, IA	0.8642	0.9049
Black Hawk, IA		
Bremer, IA		
Wausau, WI	0.9748	0.9827
Marathon, WI		
West Palm Beach-Boca Raton-Deeray Beach, FL	1.0291	1.0198
Palm Beach, FL		
Wheeling, WV-OH	0.6926	0.7776
Belmont, OH		
Marshall, WV		
Ohio, WV		
Wichita, KS	0.9809	0.9869
Butler, KS		
Harvey, KS		
Sedgwick, KS		
Wichita Falls, TX	0.8172	0.8709
Wichita, TX		
Williamsport, PA	0.8864	0.9207
Lycoming, PA		
Wilmington, DE-NJ-MD	1.0884	1.0597
New Castle, DE		
Cecil, MD		
Salem, NJ		
Wilmington, NC	0.8712	0.9099
New Hanover, NC		
Worcester-Fitchburg-Leominster, MA	0.9694	0.9789
Worcester, MA		
Yakima, WA	1.0111	1.0076
Yakima, WA		
York, PA	0.8613	0.9028
Adams, PA		
York, PA		
Youngstown-Warren, OH	0.9866	0.9908
Mahoning, OH		
Trumbull, OH		
Yuba City, CA	1.0142	1.0097
Sutter, CA		

TABLE 4a.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

[Areas that Qualify as Large Urban Areas Are Designated with an Asterisk]

Urban area (constituent counties or county equivalents)	Wage index	GAF
Yuba, Ca		
Yuma, AZ	0.8747	0.9124
Yuma, AZ		

TABLE 4b.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR RURAL AREAS

Nonurban area	Wage index	GAF
Alabama	0.7121	0.7925
Alaska	1.3498	1.2280
Arizona	0.8747	0.9124
Arkansas	0.6966	0.7807
California	1.0142	1.0097
Colorado	0.8415	0.8885
Connecticut	1.1905	1.1268
Delaware	0.8572	0.8999
Florida	0.8730	0.9112
Georgia	0.7773	0.8415
Hawaii	0.9618	0.9737
Idaho	0.9105	0.9378
Illinois	0.7700	0.8361
Indiana	0.7806	0.8440
Iowa	0.7532	0.8236
Kansas	0.7446	0.8171
Kentucky	0.7793	0.8430
Louisiana	0.7384	0.8125
Maine	0.8328	0.8822
Maryland	0.8061	0.8628
Massachusetts	1.1713	1.1144
Michigan	0.8826	0.9180
Minnesota	0.8309	0.8809
Mississippi	0.6957	0.7800
Missouri	0.7249	0.8023
Montana	0.8255	0.8769
Nebraska	0.6995	0.7829
Nevada	0.9702	0.9795
New Hampshire	0.9547	0.9688
New Jersey		
New Mexico	0.8318	0.8815
New York	0.8402	0.8876
North Carolina	0.7936	0.8536
North Dakota	0.7719	0.8375
Ohio	0.8453	0.8913
Oklahoma	0.7400	0.8137
Oregon	0.9607	0.9729
Pennsylvania	0.8613	0.9028
Puerto Rico	0.4333	0.5640
Rhode Island		
South Carolina	0.7650	0.8324
South Dakota	0.7168	0.7961
Tennessee	0.7340	0.8091
Texas	0.7591	0.8280
Utah	0.9044	0.9335
Vermont	0.9706	0.9798
Virginia	0.7826	0.8455
Washington	0.9635	0.9749
West Virginia	0.8488	0.8938
Wisconsin	0.8447	0.8908
Wyoming	0.8457	0.8916

* All counties within the State are classified urban.

TABLE 4c.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED

Area reclassified to—	Wage index	GAF
Abilene, TX	0.9429	0.9605
Aguadilla, PR	0.4568	0.5848
Akron, OH	0.8921	0.9248
Albany, GA	0.7897	0.8507
Albany-Schenectady-Troy, NY	0.8956	0.9273
Albany-Schenectady-Troy, NY (Rural Vermont Hospitals)	0.9706	0.9798
Albuquerque, NM	0.9942	0.9960
Alexandria, LA	0.8050	0.8620
Allentown-Bethlehem-Easton, PA-NJ	0.8797	0.9160
Altoona, PA	0.9238	0.9472
Amarillo, TX	0.8739	0.9118
Anaheim-Santa Ana, CA	1.1545	1.1034
Anchorage, AK	1.4000	1.2591
Ann Arbor, MI	1.1063	1.0716
Appleton-Oshkosh-Neenah, WI	0.8698	0.9089
Asheville, NC	0.8472	0.8927
Athens, GA	0.7773	0.8415
Atlanta, GA	0.9461	0.9628
Augusta, GA-SC	0.9401	0.9586
Aurora-Elgin, IL	0.8874	0.9215
Baltimore, MD	1.0156	1.0107
Bangor, ME	0.8801	0.9163
Baton Rouge, LA	0.9089	0.9367
Battle Creek, MI	0.9099	0.9374
Beaver County, PA	0.9451	0.9621
Benton Harbor, MI	0.8826	0.9180
Billings, MT	0.9049	0.9339
Biloxi-Gulfport, MS	0.7804	0.8438
Binghamton, NY	0.8868	0.9210
Birmingham, AL	0.8769	0.9140
Bismarck, ND	0.8881	0.9219
Bloomington, IN	0.7806	0.8440
Boise City, ID	0.9558	0.9695
Boston-Lawrence-Salem-Lowell-Brockton, MA	1.1574	1.1053
Boston-Lawrence-Salem-Lowell-Brockton, MA (Rural Massachusetts Hospitals)	1.1713	1.1144
Brazoria, TX	0.8792	0.9156
Bremerton, WA	1.0365	1.0249
Buffalo, NY	0.8789	0.9154
Burlington, VT	0.9018	0.9317
Burlington, VT (Rural Vermont Hospitals)	0.9706	0.9798
Caguas, PR	0.4568	0.5865
Canton, OH	0.8453	0.8913
Casper, WY	0.8773	0.9143
*Champaign-Urbana-Rantoul, IL	0.8745	0.9123
Charleston, SC	0.8171	0.8708
Charleston, WV	0.9692	0.9788
Charlotte-Gastonia-Rock Hill, NC-SC	0.9300	0.9515
Charlottesville, VA	0.9374	0.9567
Chattanooga, TN-GA	0.8878	0.9217
Cheyenne, WY	0.7499	0.8211
Chicago, IL	1.0518	1.0352
Chico, CA	1.0826	1.0559
Cincinnati, OH-KY-IN	0.9821	0.9877
Cleveland, OH	1.0475	1.0323
Columbia, MO	0.9269	0.9493
Columbia, SC	0.8748	0.9125
Columbus, GA-AL	0.7371	0.8115
Columbus, OH	0.9518	0.9667
Corpus Christi, TX	0.9638	0.9751
Dallas, TX	0.9638	0.9751
Davenport-Rock Island-Moline, IA-IL	0.8346	0.8835
Dayton-Springfield, OH	0.9646	0.9756
Daytona Beach, FL	0.8906	0.9237
Decatur, AL	0.7331	0.8085
Denver, CO	1.0762	1.0516
Des Moines, IA	0.9032	0.9327

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area reclassified to—	Wage index	GAF
Detroit, MI.....	1.0708	1.0480
Dothan, AL.....	0.7569	0.8264
Dubuque, IA.....	0.8121	0.8672
Dubuque, IA (Rural Wisconsin Hospitals).....	0.8447	0.8909
Duluth, MN-WI.....	0.9394	0.9581
Eau Claire, WI.....	0.8481	0.8933
El Paso, TX.....	0.8714	0.9100
Elkhart-Goshen, IN.....	0.8872	0.9213
Elmira, NY.....	0.8659	0.9061
Erie, PA.....	0.9155	0.9413
Eugene-Springfield, OR.....	1.0164	1.0112
Evansville, IN-KY.....	0.8959	0.9275
Fargo-Moorhead, ND-MN.....	0.9316	0.9526
Fayetteville, NC.....	0.7936	0.8536
Fayetteville-Springdale, AR.....	0.7990	0.8576
Flint, MI.....	1.1208	1.0812
Florence, AL.....	0.7717	0.8374
Florence, SC.....	0.8429	0.8896
Fort Collins-Loveland, CO.....	1.0031	1.0021
Fort Lauderdale-Hollywood-Pompano Beach, FL.....	1.0228	1.0156
Fort Myers-Cape Coral, FL.....	0.9799	0.9862
Fort Pierce, FL.....	1.0260	1.0177
Fort Smith, AR.....	0.7931	0.8532
Fort Walton Beach, FL.....	0.8941	0.9262
Fort Wayne, IN.....	0.8658	0.9060
Fort Worth-Arlington, TX.....	0.9747	0.9826
Fresno, CA.....	1.0624	1.0423
Galveston-Texas City, TX.....	0.9428	0.9605
Gary-Hammond, IN.....	0.9022	0.9319
Glens Falls, NY.....	0.8989	0.9296
Grand Forks, ND.....	0.9209	0.9451
Grand Rapids, MI.....	0.9883	0.9920
Great Falls, MT.....	0.9262	0.9489
Greeley, CO.....	0.8956	0.9273
Green Bay, WI.....	0.9278	0.9500
Greensboro-Winston-Salem-High Point, NC.....	0.8959	0.9275
Greenville-Spartanburg, SC.....	0.8768	0.9139
Hagerstown, MD.....	0.8758	0.9132
Hamilton-Middletown, OH.....	0.8435	0.8900
Harrisburg-Lebanon-Carlisle, PA.....	0.9390	0.9578
Hartford-Middletown-New Britain-Bristol, CT.....	1.1808	1.1205
Hickory, NC.....	0.8424	0.8892
Honolulu, HI.....	1.1580	1.1057
Houston, TX.....	0.9935	0.9955
Huntington-Ashland, WV-KY-OH.....	0.9255	0.9484
Huntsville, AL.....	0.8480	0.8932
Indianapolis, IN.....	0.9551	0.9690
Iowa City, IA.....	0.9327	0.9534
Jackson, MI.....	0.8826	0.9180
Jackson, MS.....	0.7593	0.8281
Jackson, TN.....	0.8073	0.8636
Jacksonville, FL.....	0.9051	0.9340
Johnson City-Kingsport-Bristol, TN-VA.....	0.8668	0.9067
Johnstown, PA.....	0.8613	0.9028
Joliet, IL.....	1.0211	1.0144
Joplin, MO.....	0.7838	0.8464
Kalamazoo, MI.....	1.1194	1.0803
Kansas City, KS-MO.....	0.9588	0.9716
Knoxville, TN.....	0.8693	0.9085
Kokomo, IN.....	0.9002	0.9305
LaCrosse, WI.....	0.8749	0.9125
Lafayette, LA.....	0.8227	0.8749
Lafayette, IN.....	0.8432	0.8898
Lake Charles, LA.....	0.8374	0.8856
Lancaster, PA.....	0.9096	0.9372
Lansing-East Lansing, MI.....	1.0046	1.0031
Las Vegas, NV.....	1.0489	1.0332
Lawrence, KS.....	0.7504	0.8215

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area reclassified to—	Wage index	GAF
Lawton, OK.....	0.8277	0.8785
Lewiston-Auburn, ME.....	0.8457	0.8916
Lexington-Fayette, KY.....	0.8323	0.8819
Lincoln, NE.....	0.8462	0.8919
Little Rock-North Little Rock, AR.....	0.8208	0.8735
Longview-Marshall, TX.....	0.8520	0.8961
Lorain-Elyria, OH.....	0.8896	0.9230
Los Angeles-Long Beach, CA.....	1.2359	1.1561
Louisville, KY-IN.....	0.8969	0.9282
Lubbock, TX.....	0.8790	0.9155
Lynchburg, VA.....	0.8389	0.8867
Macon-Warner Robins, GA.....	0.8622	0.9035
Madison, WI.....	0.9791	0.9856
Manchester-Nashua, NH.....	1.0130	1.0089
Mansfield, OH.....	0.8453	0.8913
Medford, OR.....	0.9884	0.9920
Memphis, TN-AR-MS.....	0.8772	0.9142
Merced, CA.....	1.0315	1.0215
Miami-Hialeah, FL.....	0.9955	0.9969
Middlesex-Somerset-Hunterdon, NJ.....	0.9928	0.9951
Midland, TX.....	1.0377	1.0257
Milwaukee, WI.....	0.9603	0.9726
Minneapolis-St. Paul, MN-WI.....	1.0818	1.0553
Mobile, AL.....	0.8244	0.8761
Modesto, CA.....	1.1388	1.0931
Monroe, LA.....	0.7864	0.8483
Montgomery, AL.....	0.7738	0.8389
Muncie, IN.....	0.7955	0.8550
Nashville, TN.....	0.9397	0.9583
New London-Norwich, CT.....	1.1095	1.0738
New Orleans, LA.....	0.8908	0.9239
New York, NY.....	1.3460	1.2257
Newark, NJ.....	1.0699	1.0474
Norfolk-Virginia Beach-Newport News, VA.....	0.8515	0.8958
Oakland, CA.....	1.4529	1.2915
Odessa, TX.....	1.0839	1.0567
Oklahoma City, OK.....	0.9145	0.9406
Olympia, WA.....	1.0390	1.0265
Omaha, NE-IA.....	0.8989	0.9296
Orange County, NY.....	1.0121	1.0083
Orlando, FL.....	0.9446	0.9617
Owensboro, KY.....	0.8151	0.8694
Oxnard-Ventura, CA.....	1.1792	1.1195
Panama City, FL.....	0.8632	0.9042
Parkersburg-Marietta, WV-OH.....	0.8540	0.8976
Pascagoula, MS.....	0.8771	0.9141
Peoria, IL.....	0.8710	0.9098
Philadelphia, PA-NJ.....	1.0801	1.0542
Phoenix, AZ.....	1.0429	1.0292
Pine Bluff, AR.....	0.6979	0.7817
Pittsburgh, PA.....	0.9960	0.9973
Pittsfield, MA.....	1.0119	1.0081
Portland, ME.....	0.9095	0.9371
Portland, OR.....	1.1421	1.0953
Portsmouth-Dover-Rochester, NH.....	1.0027	1.0018
Poughkeepsie, NY.....	0.9369	0.9563
Providence-Pawtucket-Woonsocket, RI.....	1.0063	1.0043
Provo-Orem, UT.....	1.0001	1.0001
Pueblo, CO.....	0.8519	0.8960
Raleigh-Durham, NC.....	0.9197	0.9443
Rapid City, SD.....	0.8284	0.8790
Redding, CA.....	1.0406	1.0276
Reno, NV.....	1.1438	1.0964
Roanoke, VA.....	0.8284	0.8790
Rochester, NY.....	0.9564	0.9699
Rockford, IL.....	0.9095	0.9371
Sacramento, CA.....	1.2253	1.1493
Saginaw-Bay City-Midland, MI.....	1.0211	1.0144
St. Cloud, MN.....	0.8919	0.9246
St. Louis, MO-IL.....	0.9248	0.9479

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area reclassified to—	Wage index	GAF
Salem, OR.....	0.9837	0.9888
Salinas-Seaside-Monterey, CA.....	1.2899	1.1904
Salt Lake City-Ogden, UT.....	0.9932	0.9953
San Angelo, TX.....	0.8139	0.8685
San Antonio, TX.....	0.8452	0.8912
San Diego, CA.....	1.1934	1.1287
San Francisco, CA.....	1.4447	1.2865
San Jose, CA.....	1.4721	1.3032
San Juan, PR.....	0.4987	0.6210
Santa Barbara-Santa Maria-Lompoc, CA.....	1.1636	1.1093
Santa Fe, NM.....	0.8856	0.9202
Santa Rosa-Petaluma, CA.....	1.2957	1.1941
Sarasota, FL.....	0.9446	0.9617
Scranton-Wilkes Barre, PA.....	0.8956	0.9202
Seattle, WA.....	1.0719	1.0487
Sharon, PA.....	0.8914	0.9243
Sheboygan, WI.....	0.8772	0.9107
Sherman-Denison, TX.....	0.8934	0.9257
Shreveport, LA.....	0.9299	0.9514
Sioux City, IA-NE.....	0.8323	0.8819
Sioux Falls, SD.....	0.8833	0.9185
South Bend-Mishawaka, IN.....	0.9686	0.9784
Spokane, WA.....	1.0691	1.0468
Springfield, IL.....	0.9193	0.9440
Springfield, MO.....	0.7915	0.8520
State College, PA.....	0.9328	0.9535
Steubenville-Weirton, OH-WV.....	0.8340	0.8831
Stockton, CA.....	1.1738	1.1193
Syracuse, NY.....	0.9514	0.9665
Tacoma, WA.....	0.9868	0.9909
Tallahassee, FL.....	0.8853	0.9200
Tampa-St. Petersburg-Clearwater, FL.....	0.9188	0.9437
Terre Haute, IN.....	0.8651	0.9055
Texarkana, TX-Texarkana, AR.....	0.7906	0.8514
Toledo, OH.....	0.8714	0.9100
Toledo, OH (Rural Michigan Hospitals).....	0.8826	0.9180
Topeka, KS.....	0.9302	0.9517
Tucson, AZ.....	0.9620	0.9738
Tulsa, OK.....	0.8398	0.8873
Tyler, TX.....	0.9330	0.9536
Vallejo-Fairfield-Napa, CA.....	1.2722	1.1792
Vancouver, WA.....	1.0124	1.0085
Victoria, TX.....	0.8839	0.9190
Waco, TX.....	0.7814	0.8446
Washington, DC-MD-VA.....	1.0941	1.0635
Waterloo-Cedar Falls, IA.....	0.8642	0.9049
Wausau, WI.....	0.9069	0.9353
West Palm Beach-Boca Raton-Deer Beach, FL.....	1.0291	1.0198
Wichita, KS.....	0.9563	0.9699
Wichita Falls, TX.....	0.8172	0.8709
Williamsport, PA.....	0.8707	0.9095
Wilmington, NC.....	0.8299	0.8801
Worcester-Fitchburg-Leominster, MA.....	0.9894	0.9789
Yakima, WA.....	0.9986	0.9990
Youngstown-Warren, OH.....	0.9507	0.9660
Rural California.....	0.9983	0.9988
Rural Connecticut.....	1.1581	1.1057
Rural Georgia.....	0.7773	0.8415
Rural Illinois.....	0.7700	0.8361
Rural Indiana.....	0.7806	0.8440
Rural Iowa.....	0.7532	0.8236
Rural Kansas.....	0.7446	0.8171
Rural Kentucky.....	0.7793	0.8430
Rural Louisiana.....	0.7384	0.8125
Rural Massachusetts.....	1.1509	1.1010
Rural Michigan.....	0.8826	0.9180
Rural Minnesota.....	0.8309	0.8809
Rural Missouri.....	0.7249	0.8023
Rural New Hampshire.....	0.9706	0.9798
Rural North Carolina.....	0.7936	0.8536

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area reclassified to—	Wage index	GAF
Rural Ohio.....	0.8453	0.8913
Rural Oklahoma.....	0.7400	0.8137
Rural Pennsylvania.....	0.8613	0.9028
Rural South Dakota.....	0.7168	0.7961
Rural Texas.....	0.7591	0.8280
Rural Utah.....	0.9044	0.9335

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area reclassified to—	Wage index	GAF
Rural Virginia.....	0.7826	0.8455
Rural Washington.....	0.9429	0.9605
Rural Washington (Rural Oregon Hospitals).....	0.9607	0.9729
Rural West Virginia.....	0.8488	0.8938
Rural Wisconsin.....	0.8447	0.8909

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area reclassified to—	Wage index	GAF
Rural Wyoming.....	0.8289	0.8794

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TABLE 5

LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM

			RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
1	01	SURG	3.2349	11.3	34
2	01	SURG	3.1227	10.7	34
3	01	SURG *	2.9677	12.7	36
4	01	SURG	2.3589	8.8	32
5	01	SURG	1.5593	5.2	28
		EXTRACRANIAL VASCULAR PROCEDURES			
6	01	SURG	.5510	2.0	22
7	01	SURG	2.5891	11.0	34
8	01	SURG	.8055	3.0	26
9	01	MED	1.2840	6.5	30
10	01	MED	1.2879	7.4	30
		NERVOUS SYSTEM NEOPLASMS WITH CC			
11	01	MED	.7738	4.3	27
12	01	MED	.9516	6.9	30
13	01	MED	.8409	6.6	30
14	01	MED	1.2178	7.0	30
15	01	MED	.6704	4.1	27
		NERVOUS SYSTEM NEOPLASMS W/O CC			
16	01	MED	1.1154	6.6	30
17	01	MED	.6477	4.4	27
18	01	MED	.9168	5.8	29
19	01	MED	.6016	4.0	27
20	01	MED	1.9823	8.6	32
		NONSPECIFIC CEREBROVASCULAR DISORDERS W/ CC			
21	01	MED	1.4613	7.2	30
22	01	MED	.7290	4.2	27
23	01	MED	.8233	4.2	27
24	01	MED	.9715	5.2	28
25	01	MED	.5330	3.4	26
		SEIZURE & HEADACHE AGE >17 WITH CC			
26	01	MED	1.0701	3.9	27
27	01	MED	1.3670	4.3	27
28	01	MED	1.2128	5.9	29
29	01	MED	.5965	3.3	26
30	01	MED *	.3599	2.0	17
		SEIZURE & HEADACHE AGE 0-17			
31	01	MED	.7696	4.4	27
32	01	MED	.4474	2.7	25
33	01	MED *	.2498	1.6	9
34	01	MED	1.1432	5.9	29
35	01	MED	.5662	3.6	27
		OTHER DISORDERS OF NERVOUS SYSTEM WITH CC			
		OTHER DISORDERS OF NERVOUS SYSTEM W/O CC			

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** DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.

NOTE: GEOMETRIC MEAN IS USED ONLY TO DETERMINE PAYMENT FOR OUTLIER AND TRANSFER CASES.

NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS.

TABLE 5

LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM

			RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
36	02	SURG	.6268	1.9	11
37	02	SURG	.7899	2.8	26
38	02	SURG	.3607	2.1	16
39	02	SURG	.4866	1.5	8
40	02	SURG	.5181	2.0	25
41	02	SURG	.3719	1.6	7
42	02	SURG	.5991	1.9	14
43	02	MED	.4101	3.7	27
44	02	MED	.5793	5.2	28
45	02	MED	.6015	3.5	26
46	02	MED	.7207	4.3	27
47	02	MED	.4203	2.9	26
48	02	MED	.4086	2.9	26
49	03	SURG	1.6364	5.0	28
50	03	SURG	.6683	2.0	13
51	03	SURG	.6320	2.1	19
52	03	SURG	.7808	2.2	18
53	03	SURG	.7264	2.0	24
54	03	SURG	.7006	3.2	22
55	03	SURG	.5480	1.7	15
56	03	SURG	.6144	1.9	17
57	03	SURG	.8995	3.3	26
58	03	SURG	.3150	1.5	4
59	03	SURG	.4367	1.5	10
60	03	SURG	.2660	1.5	4
61	03	SURG	.8791	2.6	26
62	03	SURG	.3142	1.3	5
63	03	SURG	1.0570	3.7	27
64	03	MED	1.0975	5.1	28
65	03	MED	.4944	3.3	23
66	03	MED	.4898	3.3	25
67	03	MED	.8271	4.1	27
68	03	MED	.7223	4.7	28
69	03	MED	.5038	3.6	22
70	03	MED	.6458	3.3	26

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NOTE: GEOMETRIC MEAN IS USED ONLY TO DETERMINE PAYMENT FOR OUTLIER AND TRANSFER CASES.

NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS.

TABLE 5

PAGE 3 OF 15

LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM

				RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
71	03	MED	LARYNGOTRACHEITIS	.7794	4.1	27
72	03	MED	NASAL TRAUMA & DEFORMITY	.5800	3.2	26
73	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17	.7460	4.1	27
74	03	MED	* OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0-17	.3485	2.1	20
75	04	SURG	MAJOR CHEST PROCEDURES	3.0434	11.1	34
76	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.3930	10.6	34
77	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	1.1306	5.2	28
78	04	MED	PULMONARY EMBOLISM	1.4381	8.4	31
79	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 WITH CC	1.7150	8.8	32
80	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC	.9485	6.3	29
81	04	MED	* RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0-17	1.1219	6.1	29
82	04	MED	RESPIRATORY NEOPLASMS	1.1901	6.3	29
83	04	MED	MAJOR CHEST TRAUMA WITH CC	.9477	6.0	29
84	04	MED	MAJOR CHEST TRAUMA W/O CC	.4799	3.4	26
85	04	MED	PLEURAL EFFUSION WITH CC	1.1723	6.7	30
86	04	MED	PLEURAL EFFUSION W/O CC	.6630	4.0	27
87	04	MED	PULMONARY EDEMA & RESPIRATORY FAILURE	1.3585	5.8	29
88	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	.9950	5.8	29
89	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 WITH CC	1.1478	6.9	30
90	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	.7080	5.2	28
91	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE 0-17	.9381	4.8	28
92	04	MED	INTERSTITIAL LUNG DISEASE WITH CC	1.1660	6.6	30
93	04	MED	INTERSTITIAL LUNG DISEASE W/O CC	.7374	4.7	28
94	04	MED	PNEUMOTHORAX WITH CC	1.2701	7.0	30
95	04	MED	PNEUMOTHORAX W/O CC	.5978	4.3	27
96	04	MED	BRONCHITIS & ASTHMA AGE >17 WITH CC	.9355	5.8	29
97	04	MED	BRONCHITIS & ASTHMA AGE >17 W/O CC	.6222	4.3	24
98	04	MED	BRONCHITIS & ASTHMA AGE 0-17	.9254	4.6	28
99	04	MED	RESPIRATORY SIGNS & SYMPTOMS WITH CC	.7598	3.8	27
100	04	MED	RESPIRATORY SIGNS & SYMPTOMS W/O CC	.5063	2.5	17
101	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES WITH CC	.8956	4.9	28
102	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	.5385	3.3	26
103	05	SURG	HEART TRANSPLANT	12.0076	23.5	46
104	05	SURG	CARDIAC VALVE PROCEDURES W CARDIAC CATH	7.7901	17.1	40
105	05	SURG	CARDIAC VALVE PROCEDURES W/O CARDIAC CATH	5.8509	11.9	35

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** DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.

NOTE: GEOMETRIC MEAN IS USED ONLY TO DETERMINE PAYMENT FOR OUTLIER AND TRANSFER CASES.

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TABLE 5

LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM

			RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
106	05	SURG	5.6949	13.3	36
107	05	SURG	4.2763	10.2	33
108	05	SURG	5.9112	12.3	35
109		NO LONGER VALID	.0000	.0	0
110	05	MAJOR CARDIOVASCULAR PROCEDURES WITH CC	4.0937	9.9	33
111	05	MAJOR CARDIOVASCULAR PROCEDURES W/O CC	2.3178	7.3	30
112	05	PERCUTANEOUS CARDIOVASCULAR PROCEDURES	2.0008	4.5	28
113	05	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE	2.7699	13.9	37
114	05	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	1.6038	8.9	32
115	05	PERM CARDIAC PACEMAKER IMPLANT W AMI, HEART FAILURE OR SHOCK	3.6230	11.2	34
116	05	OTH PERM CARDIAC PACEMAKER IMPLANT OR AICD LEAD OR GEN PROC C	2.4759	5.3	28
117	05	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT	1.2405	3.7	27
118	05	CARDIAC PACEMAKER DEVICE REPLACEMENT	1.6001	2.5	26
119	05	VEIN LIGATION & STRIPPING	.9692	3.5	26
120	05	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	1.9968	7.2	30
121	05	CIRCULATORY DISORDERS W AMI & C.V. COMP DISCH ALIVE	1.6191	7.8	31
122	05	CIRCULATORY DISORDERS W AMI W/O C.V. COMP DISCH ALIVE	1.1639	5.7	29
123	05	CIRCULATORY DISORDERS W AMI, EXPIRED	1.4089	2.9	26
124	05	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG	1.2107	4.2	27
125	05	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG	.7652	2.2	22
126	05	ACUTE & SUBACUTE ENDOCARDITIS	2.8616	15.5	39
127	05	HEART FAILURE & SHOCK	1.0159	5.9	28
128	05	DEEP VEIN THROMBOPHLEBITIS	.7910	7.2	30
129	05	CARDIAC ARREST, UNEXPLAINED	1.2912	2.4	25
130	05	PERIPHERAL VASCULAR DISORDERS WITH CC	.9149	6.1	29
131	05	PERIPHERAL VASCULAR DISORDERS W/O CC	.5909	4.7	28
132	05	ATHEROSCLEROSIS WITH CC	.7632	4.0	27
133	05	ATHEROSCLEROSIS W/O CC	.5347	2.9	24
134	05	HYPERTENSION	.5686	3.8	27
135	05	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE > 17 WITH CC	.8716	4.7	28
136	05	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE > 17 W/O CC	.5352	3.1	25
137	05	* CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0-17	.6422	3.3	26
138	05	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS WITH CC	.8142	4.3	27
139	05	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC	.5067	2.9	21
140	05	ANGINA PECTORIS	.6266	3.6	24

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TABLE 5

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				RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
141	05	MED	SYNCOPE & COLLAPSE WITH CC	.7030	4.2	27
142	05	MED	SYNCOPE & COLLAPSE W/O CC	.5087	3.1	22
143	05	MED	CHEST PAIN	.5202	2.7	18
144	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	1.0691	5.0	28
145	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	.6304	3.1	26
146	06	SURG	RECTAL RESECTION WITH CC	2.5585	11.9	35
147	06	SURG	RECTAL RESECTION W/O CC	1.5519	8.3	31
148	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES WITH CC	3.1528	13.0	36
149	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.5106	8.3	28
150	06	SURG	PERITONEAL ADHESIOLYSIS WITH CC	2.5671	11.3	34
151	06	SURG	PERITONEAL ADHESIOLYSIS W/O CC	1.2025	6.3	29
152	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES WITH CC	1.7859	8.8	32
153	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.0483	6.5	25
154	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE > 17 WITH CC	4.0735	14.0	37
155	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE > 17 W/O CC	1.4849	7.2	30
156	06	SURG	* STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0-17	.8524	6.0	29
157	06	SURG	ANAL & STOMAL PROCEDURES WITH CC	.9639	4.5	27
158	06	SURG	ANAL & STOMAL PROCEDURES W/O CC	.5020	2.4	17
159	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE > 17 WITH CC	1.0840	4.7	28
160	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE > 17 W/O CC	.6226	2.7	19
161	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE > 17 WITH CC	.7862	3.2	26
162	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE > 17 W/O CC	.4684	1.8	11
163	06	SURG	HERNIA PROCEDURES AGE 0-17	.4646	2.1	10
164	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG WITH CC	2.1773	8.5	32
165	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	1.2206	6.4	25
166	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG WITH CC	1.3383	5.9	29
167	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	.7850	3.6	15
168	03	SURG	MOUTH PROCEDURES WITH CC	1.0037	3.5	26
169	03	SURG	MOUTH PROCEDURES W/O CC	.5928	2.1	19
170	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES WITH CC	2.7235	10.6	34
171	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC	1.1181	5.0	28
172	06	MED	DIGESTIVE MALIGNANCY WITH CC	1.2967	7.0	30
173	06	MED	DIGESTIVE MALIGNANCY W/O CC	.6455	3.5	27
174	06	MED	G.I. HEMORRHAGE WITH CC	.9841	5.3	28
175	06	MED	G.I. HEMORRHAGE W/O CC	.5567	3.6	22

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			RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
176	06	MED	1.0421	5.8	29
177	06	MED	.7987	5.0	28
178	06	MED	.5766	3.7	22
179	06	MED	1.1102	7.0	30
180	06	MED	.9312	5.7	29
G. I. OBSTRUCTION WITH CC					
181	06	MED	.5059	3.8	25
182	06	MED	.7744	4.8	28
183	06	MED	.5350	3.4	24
184	06	MED	.4682	2.8	17
185	03	MED	.7998	4.5	27
G. I. OBSTRUCTION W/O CC					
186	03	MED	.4181	2.9	23
187	03	MED	.5799	2.6	26
188	06	MED	.9995	5.2	28
189	06	MED	.4833	2.8	26
190	06	MED	.6676	4.2	27
DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0-17					
191	07	SURG	4.4563	15.1	38
192	07	SURG	1.7402	7.7	31
193	07	SURG	3.0458	13.6	37
194	07	SURG	1.6456	7.9	31
195	07	SURG	2.2861	10.4	33
DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0-17					
196	07	SURG	1.4276	7.3	30
197	07	SURG	1.7014	6.2	29
198	07	SURG	.8839	2.7	26
199	07	SURG	2.3390	10.9	34
200	07	SURG	2.6811	8.9	32
OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES					
201	07	SURG	2.5417	10.0	33
202	07	MED	1.3029	6.9	30
203	07	MED	1.2203	6.8	30
204	07	MED	1.1201	6.0	29
205	07	MED	1.2281	6.5	30
DISORDERS OF LIVER EXCEPT MALIG, CIRRH, ALC HEPA WITH CC					
206	07	MED	.6172	3.6	27
207	07	MED	.9866	5.3	28
208	07	MED	.5603	3.1	26
209	08	SURG	2.3848	8.4	32
210	08	SURG	1.9186	10.7	34

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TABLE 5

LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM

					RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
211	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC		1.3438	8.3	31
212	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17		1.0490	4.2	27
213	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS		1.7656	9.2	32
214	08	SURG	BACK & NECK PROCEDURES WITH CC		1.8748	8.1	31
215	08	SURG	BACK & NECK PROCEDURES W/O CC		1.0872	5.1	28
216	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE		2.0448	10.0	33
217	08	SURG	WND DEBRID & SKN GRFT EXCEPT HAND, FOR MUSCULOSKELETAL & CONN TISS DIS		3.0412	13.5	37
218	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 WITH CC		1.4242	6.8	30
219	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W/O CC		.9017	4.2	26
220	08	SURG	* LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE 0-17		.9398	5.3	28
221	08	SURG	KNEE PROCEDURES WITH CC		1.7993	7.3	30
222	08	SURG	KNEE PROCEDURES W/O CC		.9709	3.7	27
223	08	SURG	MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC		.8124	3.0	22
224	08	SURG	SHOULDER, ELBOW OR FOREARM PROC, EXC MAJOR JOINT PROC, W/O CC		.6573	2.4	14
225	08	SURG	FOOT PROCEDURES		.8255	3.3	26
226	08	SURG	SOFT TISSUE PROCEDURES WITH CC		1.3386	5.8	29
227	08	SURG	SOFT TISSUE PROCEDURES W/O CC		.6847	2.8	24
228	08	SURG	MAJOR THUMB OR JOINT PROC OR OTH HAND OR WRIST PROC W CC		.8083	2.5	25
229	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC		.5587	1.9	14
230	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR		.9269	3.9	27
231	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES EXCEPT HIP & FEMUR		1.1114	3.9	27
232	08	SURG	ARTHROSCOPY		1.1827	3.6	27
233	08	SURG	OTHER MUSCULOSKELETAL SYS & CONN TISS O.R. PROC WITH CC		1.8439	8.2	31
234	08	SURG	OTHER MUSCULOSKELETAL SYS & CONN TISS O.R. PROC W/O CC		.9044	3.9	27
235	08	MED	FRACTURES OF FEMUR		1.0150	6.8	30
236	08	MED	FRACTURES OF HIP & PELVIS		.8161	6.2	29
237	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH		.5525	4.2	27
238	08	MED	OSTEOMYELITIS		1.5507	10.2	33
239	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY		1.0448	7.4	30
240	08	MED	CONNECTIVE TISSUE DISORDERS WITH CC		1.1342	6.8	30
241	08	MED	CONNECTIVE TISSUE DISORDERS W/O CC		.5842	4.3	27
242	08	MED	SEPTIC ARTHRITIS		1.1927	7.8	31
243	08	MED	MEDICAL BACK PROBLEMS		.6867	5.0	28
244	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES WITH CC		.7422	5.2	28
245	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC		.5120	3.8	27

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NOTE: GEOMETRIC MEAN IS USED ONLY TO DETERMINE PAYMENT FOR OUTLIER AND TRANSFER CASES.

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			RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
246	08	MED			
247	08	MED			
248	08	MED			
249	08	MED			
250	08	MED			
251	08	MED			
252	08	MED			
253	08	MED			
254	08	MED			
255	08	MED			
256	08	MED			
257	09	SURG			
258	09	SURG			
259	09	SURG			
260	09	SURG			
261	09	SURG			
262	09	SURG			
263	09	SURG			
264	09	SURG			
265	09	SURG			
266	09	SURG			
267	09	SURG			
268	09	SURG			
269	09	SURG			
270	09	SURG			
271	09	MED			
272	09	MED			
273	09	MED			
274	09	MED			
275	09	MED			
276	09	MED			
277	09	MED			
278	09	MED			
279	09	MED			
280	09	MED			

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			RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
281	08	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC	3.1	26
282	09	MED	* TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0-17	.4271	19
283	09	MED	MINOR SKIN DISORDERS WITH CC	.3482	28
284	09	MED	MINOR SKIN DISORDERS W/O CC	.7606	26
285	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE, NUTRIT, & METABOL DISORDERS	.4514	38
				2.7319	
286	10	SURG	ADRENAL & PITUITARY PROCEDURES	2.4111	32
287	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS	2.1723	35
288	10	SURG	O.R. PROCEDURES FOR OBESITY	2.0859	30
289	10	SURG	PARATHYROID PROCEDURES	1.0320	27
290	10	SURG	THYROID PROCEDURES	.7500	18
291	10	SURG	THYROID GLOSSAL PROCEDURES	.4939	9
292	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC WITH CC	2.8505	35
293	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC	1.1593	28
294	10	MED	DIABETES AGE >35	.7508	29
295	10	MED	DIABETES AGE 0-35	.7769	27
296	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 WITH CC	.9433	29
297	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC	.5318	27
298	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0-17	.5779	28
299	10	MED	INBORN ERRORS OF METABOLISM	.8209	27
300	10	MED	ENDOCRINE DISORDERS WITH CC	1.1212	30
301	10	MED	ENDOCRINE DISORDERS W/O CC	.5818	27
302	11	SURG	KIDNEY TRANSPLANT	3.9177	37
303	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM	2.6855	34
304	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL WITH CC	2.3886	33
305	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC	1.1708	28
306	11	SURG	PROSTATECTOMY WITH CC	1.2840	30
307	11	SURG	PROSTATECTOMY W/O CC	.6947	20
308	11	SURG	MINOR BLADDER PROCEDURES WITH CC	1.4432	29
309	11	SURG	MINOR BLADDER PROCEDURES W/O CC	.7402	28
310	11	SURG	TRANSURETHRAL PROCEDURES WITH CC	.8938	27
311	11	SURG	TRANSURETHRAL PROCEDURES W/O CC	.5215	14
312	11	SURG	URETHRAL PROCEDURES, AGE >17 WITH CC	.8169	27
313	11	SURG	URETHRAL PROCEDURES, AGE >17 W/O CC	.4667	17
314	11	SURG	* URETHRAL PROCEDURES, AGE 0-17	.4366	25
315	11	SURG	OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	2.0508	30

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				RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
316	11	MED	RENAL FAILURE	1.2942	6.2	29
317	11	MED	ADMIT FOR RENAL DIALYSIS	.5108	2.8	26
318	11	MED	KIDNEY & URINARY TRACT NEOPLASMS WITH CC	1.1258	5.9	29
319	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W/O CC	.5104	2.5	25
320	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 WITH CC	.9857	6.5	29
321	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC	.6299	4.8	27
322	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE 0-17	.6850	4.9	28
323	11	MED	URINARY STONES WITH CC, &/OR ESW LITHOTRIPSY	.7418	3.1	28
324	11	MED	URINARY STONES W/O CC	.3903	2.1	13
325	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 WITH CC	.8579	4.2	27
326	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC	.4182	2.8	22
327	11	MED	* KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0-17	.5604	3.1	26
328	11	MED	URETHRAL STRICTURE AGE >17 WITH CC	.6434	3.6	27
329	11	MED	URETHRAL STRICTURE AGE >17 W/O CC	.4147	2.1	18
330	11	MED	* URETHRAL STRICTURE AGE 0-17	.2835	1.6	9
331	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 WITH CC	.9797	5.3	28
332	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC	.5376	3.0	26
333	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0-17	.9568	5.2	28
334	12	SURG	MAJOR MALE PELVIC PROCEDURES W CC	1.7876	8.2	27
335	12	SURG	MAJOR MALE PELVIC PROCEDURES W/O CC	1.3796	6.9	19
336	12	SURG	TRANSURETHRAL PROSTATECTOMY WITH CC	.8905	4.7	25
337	12	SURG	TRANSURETHRAL PROSTATECTOMY W/O CC	.6141	3.5	12
338	12	SURG	TESTES PROCEDURES, FOR MALIGNANCY	.7881	2.8	26
339	12	SURG	TESTES PROCEDURES, NON-MALIGNANCY AGE >17	.7077	2.7	28
340	12	SURG	* TESTES PROCEDURES, NON-MALIGNANCY AGE 0-17	.4409	2.4	13
341	12	SURG	PENIS PROCEDURES	.9716	3.3	25
342	12	SURG	CIRCUMCISION AGE >17	.5888	2.5	25
343	12	SURG	* CIRCUMCISION AGE 0-17	.3852	1.7	6
344	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY	1.0639	3.9	27
345	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY	.7572	3.2	26
346	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, WITH CC	.9977	5.7	29
347	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC	.5218	2.9	26
348	12	MED	BENIGN PROSTATIC HYPERTROPHY WITH CC	.6888	4.0	27
349	12	MED	BENIGN PROSTATIC HYPERTROPHY W/O CC	.4034	2.3	20
350	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	.6739	4.8	28

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				RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
351	12	MED	* STERILIZATION, MALE		1.3	5
352	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	.3390		
353	13	SURG	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY	.5853	3.2	26
354	13	SURG	UTERINE, ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG WITH CC	1.9325	9.3	32
355	13	SURG	UTERINE, ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC	1.3856	6.8	30
				.8607	4.7	12
356	13	SURG	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	.7087	3.8	15
357	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIG	2.3204	10.0	33
358	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY WITH CC	1.1154	5.6	22
359	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	.7796	4.2	11
360	13	SURG	VAGINA, CERVIX & VULVA PROCEDURES	.8119	4.0	27
361	13	SURG	LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	.9995	3.6	27
362	13	SURG	ENDOSCOPIC TUBAL INTERRUPTION	.5066	1.4	5
363	13	SURG	D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	.6328	3.0	25
364	13	SURG	D&C, CONIZATION EXCEPT FOR MALIGNANCY	.5703	2.6	26
365	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	1.7333	7.1	30
366	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM WITH CC	1.2102	6.4	29
367	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC	.4966	2.7	26
368	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	.8830	5.8	29
369	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	.5461	3.2	26
370	14	SURG	CESAREAN SECTION W CC	.8892	5.2	24
371	14	SURG	CESAREAN SECTION W/O CC	.6447	4.0	11
372	14	MED	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	.4679	2.9	19
373	14	MED	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	.3189	2.1	8
374	14	SURG	VAGINAL DELIVERY W STERILIZATION &/OR D&C	.6246	2.8	23
375	14	SURG	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	.6933	4.4	27
376	14	MED	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	.3194	2.2	15
377	14	SURG	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	.8445	3.6	27
378	14	MED	ECTOPIC PREGNANCY	.7802	3.3	14
379	14	MED	THREATENED ABORTION	.2845	2.0	20
380	14	MED	ABORTION W/O D&C	.3497	1.9	20
381	14	SURG	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	.4250	1.7	13
382	14	MED	FALSE LABOR	.1520	1.3	5
383	14	MED	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	.3924	3.2	26
384	14	MED	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	.2893	2.0	19
385	15	MED	* NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	1.2439	1.8	25

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			RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
386	15	MED	* EXTREME IMMATUREITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE		
387	15	MED	* PREMATURITY W MAJOR PROBLEMS	17.9	41
388	15	MED	* PREMATURITY W/O MAJOR PROBLEMS	13.3	36
389	15	MED	* FULL TERM NEONATE W MAJOR PROBLEMS	8.6	32
390	15	MED	NEONATE W OTHER SIGNIFICANT PROBLEMS	4.7	28
				4.2	27
391	15	MED	* NORMAL NEWBORN		
392	16	SURG	SPLENECTOMY AGE >17	3.1	11
393	16	SURG	* SPLENECTOMY AGE 0-17	11.1	34
394	16	SURG	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS	1.5483	32
395	16	MED	RED BLOOD CELL DISORDERS AGE >17	5.6	29
				4.6	28
396	16	MED	RED BLOOD CELL DISORDERS AGE 0-17		
397	16	MED	COAGULATION DISORDERS	2.0	24
398	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS WITH CC	1.1954	28
399	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC	1.2163	29
400	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE	.8632	27
				2.5529	32
401	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC		
402	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC	2.4112	33
403	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	.8893	27
404	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	1.8775	31
405	17	MED	* ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0-17	.7522	27
				1.0583	28
406	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W CC		
407	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W/O CC	2.7902	34
408	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R. PROC	1.2024	28
409	17	MED	RADIOTHERAPY	1.3730	28
410	17	MED	CHEMOTHERAPY WITHOUT ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	.8920	29
				.6140	20
411	17	MED	HISTORY OF MALIGNANCY W/O ENDOSCOPY		
412	17	MED	HISTORY OF MALIGNANCY W ENDOSCOPY	.4698	25
413	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG WITH CC	.4072	17
414	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC	1.3256	30
415	18	SURG	O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES	.6849	27
				3.4871	37
416	18	MED	SEPTICEMIA AGE >17		
417	18	MED	SEPTICEMIA AGE 0-17	1.5203	30
418	18	MED	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	.8950	27
419	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 WITH CC	.9709	29
420	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	.9519	29
				.6570	27

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					RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
421	18	MED	VIRAL ILLNESS AGE >17		.6849	4.3	27
422	18	MED	VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0-17		.7358	4.8	28
423	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES		1.5481	7.7	31
424	19	SURG	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS		2.3554	13.5	36
425	19	MED	ACUTE ADJUST REACT & DISTURBANCES OF PSYCHOSOCIAL DYSFUNCTION		.7086	4.5	27
426	19	MED	DEPRESSIVE NEUROSES		.6031	5.1	28
427	19	MED	NEUROSES EXCEPT DEPRESSIVE		.6348	5.1	28
428	19	MED	DISORDERS OF PERSONALITY & IMPULSE CONTROL		.7701	6.5	29
429	19	MED	ORGANIC DISTURBANCES & MENTAL RETARDATION		.8448	7.6	31
430	19	MED	PSYCHOSES		.9030	8.5	32
431	19	MED	CHILDHOOD MENTAL DISORDERS		.6180	5.1	28
432	19	MED	OTHER MENTAL DISORDER DIAGNOSES		.7081	4.5	27
433	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA		.3596	2.9	26
434	20	MED	ALC/DRUG ABUSE OR DEPENDENCE, DETOX OR OTHER SYMPT TRT WITH CC		.7590	5.4	28
435	20	MED	ALC/DRUG ABUSE OR DEPENDENCE, DETOX OR OTHER SYMPT TRT W/O CC		.4876	4.4	27
436	20	MED	ALC/DRUG DEPENDENCE W REHABILITATION THERAPY		1.0080	15.0	38
437	20	MED	ALC/DRUG DEPENDENCE, COMBINED REHAB & DETOX THERAPY		1.1011	14.2	37
438			NO LONGER VALID		.0000	.0	0
439	21	SURG	SKIN GRAFTS FOR INJURIES		1.2262	5.5	28
440	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES		1.8295	8.1	31
441	21	SURG	HAND PROCEDURES FOR INJURIES		.7437	2.4	25
442	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES WITH CC		1.9129	5.9	29
443	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W/O CC		.7604	2.6	26
444	21	MED	TRAUMATIC INJURY AGE > 17 W CC		.7848	5.2	28
445	21	MED	TRAUMATIC INJURY AGE > 17 W/O CC		.4685	3.4	26
446	21	MED	* TRAUMATIC INJURY AGE 0-17		.4877	2.4	22
447	21	MED	ALLERGIC REACTIONS AGE >17		.4905	2.5	24
448	21	MED	* ALLERGIC REACTIONS AGE 0-17		.3529	2.9	17
449	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 WITH CC		.7899	4.0	27
450	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC		.4374	2.3	22
451	21	MED	* POISONING & TOXIC EFFECTS OF DRUGS AGE 0-17		.5277	2.1	17
452	21	MED	COMPLICATIONS OF TREATMENT WITH CC		.8540	4.2	27
453	21	MED	COMPLICATIONS OF TREATMENT W/O CC		.4220	2.7	23
454	21	MED	OTHER INJURY, POISONING & TOXIC EFF DIAG WITH CC		.8886	4.3	27
455	21	MED	OTHER INJURY, POISONING & TOXIC EFF DIAG W/O CC		.4160	2.4	21

* MEDICARE DATA HAVE BEEN SUPPLEMENTED BY DATA FROM MARYLAND AND MICHIGAN FOR LOW VOLUME DRGS.

** DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.

NOTE: GEOMETRIC MEAN IS USED ONLY TO DETERMINE PAYMENT FOR OUTLIER AND TRANSFER CASES.

NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS.

TABLE 5

LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM

			RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
456	22	MED	1.7210	4.4	27
457	22	MED	2.0868	3.8	27
458	22	SURG	3.8990	18.0	39
459	22	SURG	1.9178	10.1	33
460	22	MED	1.0043	6.2	29
461	23	SURG	.9111	2.7	26
462	23	MED	1.7740	13.7	37
463	23	MED	.7333	4.8	28
464	23	MED	.4618	3.1	26
465	23	MED	.3474	1.8	17
466	23	MED	.5332	2.4	25
467	23	MED	.4384	2.7	26
468			3.2644	12.6	36
469			.0000	.0	0
470			.0000	.0	0
471	08	SURG	3.9172	11.9	35
472	22	SURG	11.6267	16.0	39
473	17	MED	3.4700	9.7	33
474	04		.0000	.0	0
475	04	MED	3.5025	9.4	32
476			2.1952	13.5	36
477			1.4308	5.9	29
478	05	SURG	2.1789	6.8	30
479	05	SURG	1.2851	4.1	27
480			21.8486	28.1	51
481			15.5389	41.0	64
482			3.4816	13.6	37
483			16.2845	42.5	66
484	24	SURG	6.6212	14.9	38
485	24	SURG	3.1328	12.9	36
486	24	SURG	4.7689	10.6	34
487	24	MED	1.8666	7.5	31
488	25	SURG	3.5333	14.9	38
489	25	MED	1.8532	9.0	32
490	25	MED	1.1221	5.4	28

* MEDICARE DATA HAVE BEEN SUPPLEMENTED BY DATA FROM MARYLAND AND MICHIGAN FOR LOW VOLUME DRGS.

** DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.

NOTE: GEOMETRIC MEAN IS USED ONLY TO DETERMINE PAYMENT FOR OUTLIER AND TRANSFER CASES.

NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS.

TABLE 5

LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM

		RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
491 08 SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES - UPPER EXTREMITY	1.5760	5.3	28
492 17 MED	CHEMOTHERAPY WITH ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	2.9124	8.6	32

* MEDICARE DATA HAVE BEEN SUPPLEMENTED BY DATA FROM MARYLAND AND MICHIGAN FOR LOW VOLUME DRGS.

** DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.

NOTE: GEOMETRIC MEAN IS USED ONLY TO DETERMINE PAYMENT FOR OUTLIER AND TRANSFER CASES.

NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS.

TABLE 6a.—NEW DIAGNOSIS CODES

Diagnosis code	Description	CC	MDC	DRG
008.00	Intestinal infection due to unspecified <i>E. coli</i>	N	06	182, 183, 184
008.01	Intestinal infection due to enteropathogenic <i>E. coli</i>	N	06	182, 183, 184
008.02	Intestinal infection due to enterotoxigenic <i>E. coli</i>	N	06	182, 183, 184
008.03	Intestinal infection due to enteroinvasive <i>E. coli</i>	N	06	182, 183, 184
008.04	Intestinal infection due to enterohemorrhagic <i>E. coli</i>	N	06	182, 183, 184
008.09	Intestinal infection due to other intestinal <i>E. coli</i> infections.....	N	06	182, 183, 184
008.43	Intestinal infection due to <i>Campylobacter</i>	N	06	182, 183, 184
008.44	Intestinal infection due to <i>Yersinia enterocolitica</i>	N	06	182, 183, 184
008.45	Intestinal infection due to <i>Clostridium difficile</i>	N	06	182, 183, 184
008.46	Intestinal infection due to other anaerobes.....	N	06	182, 183, 184
008.47	Intestinal infection due to other gram-negative bacteria.....	N	06	182, 183, 184
008.61	Enteritis due to Rotavirus.....	N	06	182, 183, 184
008.62	Enteritis due to Adenovirus.....	N	06	182, 183, 184
008.63	Enteritis due to Norwalk virus.....	N	06	182, 183, 184
008.64	Enteritis due to other small round viruses (SRV's).....	N	06	182, 183, 184
008.65	Enteritis due to Calicivirus.....	N	06	182, 183, 184
008.66	Enteritis due to Astrovirus.....	N	06	182, 183, 184
008.67	Enteritis due to Enterovirus not elsewhere classified.....	N	06	182, 183, 184
008.69	Enteritis due to other viruses.....	N	06	182, 183, 184
041.00	Bacterial infection due to unspecified <i>Streptococcus</i>	N	18	423
041.01	Bacterial infection due to <i>Streptococcus</i> , Group A.....	N	18	423
041.02	Bacterial infection due to <i>Streptococcus</i> , Group B.....	N	18	423
041.03	Bacterial infection due to <i>Streptococcus</i> , Group C.....	N	18	423
041.04	Bacterial infection due to <i>Streptococcus</i> , Group D.....	N	18	423
041.05	Bacterial infection due to <i>Streptococcus</i> , Group G.....	N	18	423
041.09	Bacterial infection due to other <i>Streptococcus</i>	N	18	423
041.10	Bacterial infection due to unspecified <i>Staphylococcus</i>	N	18	423
041.11	Bacterial infection due to <i>Staphylococcus aureus</i>	N	18	423
041.19	Bacterial infection due to other <i>Staphylococcus</i>	N	18	423
041.81	Bacterial infection due to <i>Mycoplasma</i>	N	18	423
041.82	Bacterial infection due to <i>Bacillus fragilis</i>	N	18	423
041.83	Bacterial infection due to <i>Clostridium perfringens</i>	N	18	423
041.84	Bacterial infection due to other anaerobes.....	N	18	423
041.85	Bacterial infection due to other gram-negative organisms.....	N	18	423
041.89	Bacterial infection due to other specified bacteria.....	N	18	423
099.40	Unspecified nongonococcal urethritis (NGU).....	N	12	423
099.41	Venereal urethritis due to <i>Chlamydia trachomatis</i>	N	12	358, 359, 368
099.49	Venereal urethritis due to other specified organism.....	N	12	350
099.50	<i>Chlamydia trachomatis</i> infection of unspecified site.....	N	12	358, 359, 368
		13	358, 359, 368	350
099.51	<i>Chlamydia trachomatis</i> infection of pharynx.....	N	03	68, 69, 70
099.52	<i>Chlamydia trachomatis</i> infection of anus and rectum.....	N	06	188, 189, 190
099.53	<i>Chlamydia trachomatis</i> infection of lower genitourinary sites.....	N	12	350
099.54	<i>Chlamydia trachomatis</i> infection of other genitourinary sites.....	N	11	358, 359, 368
099.55	<i>Chlamydia trachomatis</i> infection of unspecified genitourinary site.....	N	12	320, 321, 322
099.56	<i>Chlamydia trachomatis</i> infection of peritoneum.....	N	13	350
099.59	<i>Chlamydia trachomatis</i> infection of other specified site.....	N	06	358, 359, 368
112.84	Candidiasis of the esophagus.....	Y	06	188, 189, 190
			15	387, 389
112.85	Candidiasis of the intestine.....	Y	25	489
			06	182, 183, 184
			15	387, 389
320.81	Meningitis due to anaerobic bacteria.....	Y	01	489
			15	20
320.82	Meningitis due to gram-negative bacteria, not elsewhere classified.....	Y	01	387, 389
			15	20
320.89	Meningitis due to other specified bacteria.....	Y	01	387, 389
			15	20
346.00	Classical migraine without mention of intractable migraine.....	N	01	387, 389
346.01	Classical migraine with intractable migraine, so stated.....	N	01	24, 25, 26
346.10	Common migraine without mention of intractable migraine.....	N	01	24, 25, 26
346.11	Common migraine with intractable migraine, so stated.....	N	01	24, 25, 26
346.20	Variants of migraine without mention of intractable migraine.....	N	01	24, 25, 26
346.21	Variants of migraine with intractable migraine, so stated.....	N	01	24, 25, 26
346.80	Other forms of migraine without mention of intractable migraine.....	N	01	24, 25, 26
346.81	Other forms of migraine with intractable migraine, so stated.....	N	01	24, 25, 26
346.90	Migraine, unspecified, without mention of intractable migraine.....	N	01	24, 25, 26
346.91	Migraine, unspecified, with intractable migraine, so stated.....	N	01	24, 25, 26
371.82	Corneal disorder due to contact lens.....	N	02	24, 25, 26
437.7	Transient global amnesia.....	N	01	46, 47, 48
				16, 17

TABLE 6a.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	DRG
440.20	Atherosclerosis of arteries of the extremities, unspecified	N	05	130, 131
440.21	Atherosclerosis of arteries of the extremities with intermittent claudication	N	05	130, 131
440.22	Atherosclerosis of arteries of the extremities with rest pain	N	05	130, 131
482.30	Pneumonia due to unspecified Streptococcus	Y	04	89, 90, 91
			15	1387, 389
			25	489
482.31	Pneumonia due to Streptococcus, Group A	Y	04	89, 90, 91
			15	1387, 389
			25	489
	D	25	489	
482.32	Pneumonia due to Streptococcus, Group B	Y	04	89, 90, 91
			15	1387, 389
			25	489
482.32	Pneumonia due to Streptococcus, Group B	Y	04	89, 90, 91
			15	1387, 389
			25	489
482.39	Pneumonia due to other Streptococcus	Y	04	89, 90, 91
			15	1387, 389
			25	489
482.81	Pneumonia due to anaerobes	Y	04	79, 80, 81
			15	1387, 389
			25	489
482.82	Pneumonia due to Escherichia coli [E. coli]	Y	04	79, 80, 81
			15	1387, 389
			25	489
482.83	Pneumonia due to other gram-negative bacteria	Y	04	79, 80, 81
			15	1387, 389
			25	489
482.89	Pneumonia due to other specified bacteria	Y	04	79, 80, 81
			15	1387, 389
			25	489
483.0	Pneumonia due to Mycoplasma pneumoniae	Y	04	89, 90, 91
			15	1387, 389
483.8	Pneumonia due to other specified organism	Y	04	89, 90, 91
			15	1387, 389
524.00	Unspecified anomaly of jaw size	N	03	185, 186, 187
			—	482
524.01	Maxillary hyperplasia	N	03	185, 186, 187
			—	482
524.02	Mandibular hyperplasia	N	03	185, 186, 187
			—	482
524.03	Maxillary hypoplasia	N	03	185, 186, 187
			—	482
524.04	Mandibular hypoplasia	N	03	185, 186, 187
			—	482
524.05	Macrogenia	N	03	185, 186, 187
			—	482
524.06	Microgenia	N	03	185, 186, 187
			—	482
524.09	Other specified anomaly of jaw size	N	03	185, 186, 187
			—	482
524.10	Unspecified anomaly of relationship of jaw to cranial base	N	03	185, 186, 187
			—	482
524.11	Maxillary asymmetry	N	03	185, 186, 187
			—	482
524.12	Other jaw asymmetry	N	03	185, 186, 187
			—	482
524.19	Other specified anomaly of relationship of jaw to cranial base	N	03	185, 186, 187
			—	482
524.70	Unspecified alveolar anomaly	N	03	185, 186, 187
			—	482
524.71	Alveolar maxillary hyperplasia	N	03	185, 186, 187
			—	482
524.72	Alveolar mandibular hyperplasia	N	03	185, 186, 187
			—	482
524.73	Alveolar maxillary hypoplasia	N	03	185, 186, 187
			—	482
524.74	Alveolar mandibular hypoplasia	N	03	185, 186, 187
			—	482
524.79	Other specified alveolar anomaly	N	03	185, 186, 187
			—	482
596.51	Hypertonicity of bladder	N	11	331, 332, 333
596.52	Low bladder compliance	N	11	331, 332, 333
596.53	Paralysis of bladder	N	11	331, 332, 333
596.54	Neurogenic bladder, not otherwise specified	N	11	331, 332, 333
596.55	Detrusor sphincter dyssynergia	N	11	331, 332, 333
596.59	Other functional disorder of bladder	N	11	331, 332, 333
599.81	Urethral hypermobility	N	11	331, 332, 333
599.82	Intrinsic (urethral) sphincter deficiency [ISD]	N	11	331, 332, 333
599.83	Urethral instability	N	11	331, 332, 333

TABLE 6a.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	DRG
599.84	Other specified disorders of urethra	N	11	331, 332, 333
599.89	Other specified disorders of urinary tract	N	11	331, 332, 333
659.60	Other advanced maternal age, unspecified as to episode of care or not applicable	N	14	370, 371, 372, 373, 374, 375
659.61	Other advanced maternal age, delivered, with or without mention of antepartum condition	N	14	370, 371, 372, 373, 374, 375
659.63	Other advanced maternal age, antepartum condition or complication	N	14	383, 384
692.72	Acute dermatitis due to solar radiation	N	09	283, 284
692.73	Actinic reticuloid and actinic granuloma	N	09	283, 284
692.74	Other chronic dermatitis due to solar radiation	N	09	283, 284
692.82	Dermatitis due to other radiation	N	09	283, 284
692.83	Dermatitis due to metals	N	09	283, 284
710.5	Eosinophilia myalgia syndrome	Y	09	240, 241
738.10	Unspecified acquired deformity of head	N	08	256
738.11	Zygomatic hyperplasia	N	08	256
738.12	Zygomatic hypoplasia	N	08	256
738.19	Other specified acquired deformity of head	N	08	256
780.01	Coma	Y	01	23
780.02	Transient alteration of awareness	N	15	¹ 387, 389
780.09	Other alteration of consciousness	N	01	23
780.57	Other and unspecified sleep apnea	N	01	23
788.30	Unspecified urinary incontinence	N	11	34, 35
788.31	Urge incontinence	N	11	325, 326, 327
788.32	Stress incontinence, male	N	11	325, 326, 327
788.33	Mixed incontinence, urge and stress	N	11	325, 326, 327
788.34	Incontinence without sensory awareness	N	11	325, 326, 327
788.35	Post-void dribbling	N	11	325, 326, 327
788.36	Nocturnal enuresis	N	11	325, 326, 327
788.37	Continuous leakage	N	11	325, 326, 327
788.39	Other urinary incontinence	N	11	325, 326, 327
864.05	Injury to liver without mention of open wound into cavity, unspecified laceration	Y	07	205, 206
864.15	Injury to liver with open wound into cavity, unspecified laceration	Y	24	² 487
V07.4	[Need for] prophylactic postmenopausal hormone replacement therapy	N	23	467
V25.43	[Encounter for] surveillance of implantable subdermal contraceptive	N	23	467
V25.5	[Encounter for] insertion of implantable subdermal contraceptive	N	23	467
V29.0	Observation and evaluation of newborns and infants for suspected infectious condition not found.	N	15	³ 391
V29.1	Observation and evaluation of newborns and infants for suspected neurological condition not found.	N	23	467
V29.8	Observation and evaluation of newborns and infants for other specified suspected condition not found.	N	15	³ 391
V29.9	Observation and evaluation of newborns and infants for unspecified suspected condition not found.	N	23	467
			15	³ 391
			23	467

¹ Diagnosis code is classified as a "major problem" in these DRGs.² Diagnosis code is assigned to the "Significant Abdominal Trauma" body site category.³ Diagnosis code is considered in this classification only if it is a secondary diagnosis.

TABLE 6B.—NEW PROCEDURE CODES

Procedure code	Description	OR	MDC	DRG
02.96	Insertion of sphenoidal electrodes	N		
66.01	Salpingotomy	Y	13	354, 355, 357, 358, and 359.
66.02	Salpingostomy	Y	13	354, 355, 357, 358, and 359.
68.9	Other and unspecified hysterectomy	Y	13	354, 355, 357, 358, and 359.
			14	375
81.97	Revision of joint replacement of upper extremity	Y	08, 21, and 24	233, 234, 442, 443, and 486.

TABLE 6C.—INVALID DIAGNOSIS CODES ¹

Diagnosis code	Description	CC	MDC	DRG
008.0	Intestinal infection due to Escherichia coli [E. coli]	N	06	182, 183, and 184.
008.6	Enteritis due to specified virus	N	06	182, 183, and 184.
041.0	Bacterial infection due to Streptococcus	N	18	423.
041.1	Bacterial infection due to Staphylococcus	N	18	423.
041.8	Other specified bacterial infections	N	18	423.

TABLE 6C.—INVALID DIAGNOSIS CODES ¹—Continued

Diagnosis code	Description	CC	MDC	DRG
089.4	Other nongonococcal urethritis.....	N 13	12 358, 359, and 368..	350.
320.8	Meningitis due to other specified bacteria	Y	01 and 15	20, 387, and 389. ²
346.0	Classical migraine	N	01	24, 25, and 26.
346.1	Common migraine	N	01	24, 25, and 26.
346.2	Variants of migraine	N	01	24, 25, and 26.
346.8	Other forms of migraine	N	01	24, 25, and 26.
346.9	Migraine, unspecified	N	01	24, 25, and 26.
440.2	Atherosclerosis of arteries of the extremities	N	05	130, 131.
482.3	Pneumonia due to Streptococcus	Y	04	89, 90, and 91.
482.8	Pneumonia due to other specified bacteria	Y	04	79, 80, and 81.
483	Pneumonia due to other specified organism	Y	04	89, 90, and 91.
524.0	Major anomalies of jaw size	N	03	185, 186, and 187.
524.1	Anomalies of relationship of jaw to cranial base	N	03	185, 186, and 187.
596.5	Other functional disorders of bladder	N	11	331, 332, and 333.
599.8	Other specified disorders of urethra and urinary tract	N	11	331, 332, and 333.
738.1	Other acquired deformity of head	N	08	256.
780.0	Coma and stupor	Y	01	23.
788.3	Incontinence of urine	N	11	325, 326, and 327.

¹ See Table 6a for new diagnosis codes (4- or 5-digits) that will be considered valid by the FY 1993 GROUPE.² Diagnosis code is classified as a "major problem" in these DRGs.

TABLE 6D.—INVALID PROCEDURE CODES

Procedure code	Description	OR	MDC	DRG
46.12	Permanent magnetic colostomy	Y	06, 17, 21, and 24.	148, 149, 400, 406, 407, 442, 443, and 486.
69.11	Removal of intraligamentous ectopic pregnancy	Y	13 and 14	354, 355, 357, 358, 359, and 375.
89.49	Artificial pacemaker slew rate check	N		

Table 6E.—REVISED DIAGNOSIS CODE TITLES

Diagnosis code	Description	CC	MDC	DRG
079.8	Other specified viral and Chlamydial infections	N	18	421, 422.
079.9	Unspecified viral and Chlamydial infection	N	18	421, 422.
200.00	Reticulosarcoma, unspecified site, extranodal and solid organ sites	Y	17	400, 401, 402, 403, and 404.
200.10	Lymphosarcoma, unspecified site, extranodal and solid organ sites		17	400, 401, 402, 403, and 404.
200.20	Burkitt's tumor or lymphoma, unspecified site, extranodal and solid organ sites		17	400, 401, 402, 403, and 404.
200.80	Other named variants, unspecified site, extranodal and solid organ sites		17	400, 401, 402, 403, and 404.
201.00	Hodgkin's paraneoplasia, unspecified site, extranodal and solid organ sites		17	400, 401, 402, 403, and 404.
201.10	Hodgkin's granuloma, unspecified site, extranodal and solid organ sites		17	400, 401, 402, 403, and 404.
201.20	Hodgkins sarcoma, unspecified site, extranodal and solid organ sites		17	400, 401, 402, 403, and 404.
201.40	Lymphocytic-histiocytic predominance, unspecified site, extranodal and solid organ sites		17	400, 401, 402, 403, and 404.
201.50	Nodular sclerosis, unspecified site, extranodal and solid organ sites		17	400, 401, 402, 403, and 404.
201.60	Mixed cellularity, unspecified site, extranodal and solid organ sites		17	400, 401, 402, 403, and 404.
201.70	Lymphocytic depletion, unspecified site, extranodal and solid organ sites		17	400, 401, 402, 403, and 404.
201.90	Hodgkin's disease, unspecified site, extranodal and solid organ sites		17	400, 401, 402, 403, and 404.
202.00	Nodular lymphoma, unspecified site, extranodal and solid organ sites		17	400, 401, 402, 403, and 404.
202.10	Mycosis fungoides, unspecified site, extranodal and solid organ sites		17	400, 401, 402, 403, and 404.
202.20	Sezary's disease, unspecified site, extranodal and solid organ sites		17	400, 401, 402, 403, and 404.
202.30	Malignant histiocytosis, unspecified site, extranodal and solid organ sites		17	400, 401, 402, 403, and 404.
202.40	Leukemic reticuloendotheliosis, unspecified site, extranodal and solid organ sites		17	400, 401, 402, 403, and 404.
202.50	Letterer-Siwe disease, unspecified site, extranodal and solid organ sites		17	406, 407, 408, 413, and 414.
202.60	Malignant mast cell tumors, unspecified site, extranodal and solid organ sites		17	400, 401, 402, 403, and 404.
202.80	Other lymphomas, unspecified site, extranodal and solid organ sites		17	400, 401, 402, 403, and 404.
202.90	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue, unspecified site, extranodal and solid organ sites		17	400, 401, 402, 403, and 404.
481	Pneumococcal pneumonia [Streptococcus pneumoniae pneumonia]		04	89, 89, 91.
654.20	Previous cesarean delivery, unspecified as to episode of care or not applicable	N	14	469.
654.21	Previous cesarean delivery, delivered, with or without mention of antepartum condition	N	14	370, 371, 372, 373, 374, and 375.
654.23	Previous cesarean delivery, antepartum condition or complication	N	14	383, 384.
665.10	Rupture of uterus during labor, unspecified as to episode of care or not applicable		14	370, 371, 372, 373, 374, and 375.
665.11	Rupture of uterus during labor, delivered, with or without mention of antepartum condition		14	370, 371, 372, 373, 374, and 375.
665.12	Rupture of uterus during labor, delivered, with mention of postpartum complication		14	370, 371, 372, 373, 374, and 375.

Table 6E.—REVISED DIAGNOSIS CODE TITLES—Continued

Diagnosis code	Description	CC	MDC	DRG
665.14	Rupture of uterus during labor, postpartum condition or complication.....		14	376, 377.
692.79	Other dermatitis due to solar radiation.....	N	09	283, 284.
768.4	Fetal distress, unspecified as to time of onset, in liveborn infant.....	N	15	390.
785.2	Undiagnosed cardiac murmurs.....	N	05	135, 136, 137.
V30.00	Single liveborn, born in hospital, delivered without mention of cesarean delivery.....	N	15	391.
V30.01	Single liveborn, born in hospital, delivered by cesarean delivery.....	N	15	391.
V31.00	Twin, mate liveborn, born in hospital, delivered without mention of cesarean delivery.....	N	15	391.
V31.01	Twin, mate liveborn, born in hospital, delivered by cesarean delivery.....	N	15	391.
V32.00	Twin, mate stillborn, born in hospital, delivered without mention of cesarean delivery.....	N	15	391.
V32.01	Twin, mate stillborn, born in hospital, delivered by cesarean delivery.....	N	15	391.
V33.00	Twin, unspecified, born in hospital, delivered without mention of cesarean delivery.....	N	15	391.
V33.01	Twin, unspecified, born in hospital, delivered by cesarean delivery.....	N	15	391.
V34.00	Other multiple, mates all liveborn, born in hospital, delivered without mention of cesarean.....	N	15	391.
V34.01	Other multiple, mates all liveborn, born in hospital, delivered by cesarean delivery.....	N	15	391.
V35.00	Other multiple, mates all stillborn, born in hospital, delivered without mention of cesarean delivery.....	N	15	391.
V35.01	Other multiple, mates all stillborn, born in hospital, delivered by cesarean delivery.....	N	15	391.
V36.00	Other multiple, mates live- and stillborn, born in hospital, delivered without mention of cesarean delivery.....	N	15	391.
V36.01	Other multiple, mates live- and stillborn, born in hospital, delivered by cesarean delivery.....	N	15	391.
V37.00	Other multiple, unspecified, born in hospital, delivered without mention of cesarean delivery.....	N	15	391.
V37.01	Other multiple, unspecified, born in hospital, delivered by cesarean delivery.....	N	15	391.
V39.00	Liveborn infant, type of birth unspecified, born in hospital, delivered without mention of cesarean delivery.....	N	15	391.
V39.01	Liveborn infant, type of birth unspecified, born in hospital, delivered by cesarean delivery.....	N	15	391.
V73.8	Other specific viral and Chlamydial diseases.....	N	23	467.

TABLE 6F.—REVISED PROCEDURE CODE TITLES

Procedure code	Description	OR	MDC	DRG
04.01	Excision of acoustic neuroma.....	Y	01	1, 2, 3.
46.13	Permanent colostomy.....	Y	03	63.
			06	148, 149.
			17	400, 406, 407.
			21	442, 443.
			24	486.
54.91	Percutaneous abdominal drainage.....	N		
74.3	Removal of extratubal ectopic pregnancy.....	Y	14	375.
81.59	Revision of joint replacement of lower extremity, not elsewhere classified.....	Y	08	233, 234.
			21	21.
			24	442, 443.
				486.

Table 6g - Additions to the CC Exclusions List

CCs that are added to the list are in Table 6g-Additions to the CC Exclusions List. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.

*00321	48289	4830	4838	*01126	48230	48231	48232
32081	4830	4838	*01121	48230	48231	48232	48239
32082	4838	*01113	48230	48231	48232	48239	48281
32089	*01105	48230	48231	48232	48239	48281	48282
*01100	48230	48231	48232	48239	48281	48282	48283
48230	48231	48232	48239	48281	48282	48283	48289
48231	48232	48239	48281	48282	48283	48289	4830
48232	48239	48281	48282	48283	48289	4830	4838
48239	48281	48282	48283	48289	4830	4838	*01151
48281	48282	48283	48289	4830	4838	*01143	48230
48282	48283	48289	4830	4838	*01135	48230	48231
48283	48289	4830	4838	*01130	48230	48231	48232
48289	4830	4838	*01122	48230	48231	48232	48239
4830	4838	*01114	48230	48231	48232	48239	48281
4838	*01106	48230	48231	48232	48239	48281	48282
*01101	48230	48231	48232	48239	48281	48282	48283
48230	48231	48232	48239	48281	48282	48283	48289
48231	48232	48239	48281	48282	48283	48289	4830
48232	48239	48281	48282	48283	48289	4830	4838
48239	48281	48282	48283	48289	4830	4838	*01152
48281	48282	48283	48289	4830	4838	*01144	48230
48282	48283	48289	4830	4838	*01136	48230	48231
48283	48289	4830	4838	*01131	48230	48231	48232
48289	4830	4838	*01123	48230	48231	48232	48239
4830	4838	*01115	48230	48231	48232	48239	48281
4838	*01110	48230	48231	48232	48239	48281	48282
*01102	48230	48231	48232	48239	48281	48282	48283
48230	48231	48232	48239	48281	48282	48283	48289
48231	48232	48239	48281	48282	48283	48289	4830
48232	48239	48281	48282	48283	48289	4830	4838
48239	48281	48282	48283	48289	4830	4838	*01153
48281	48282	48283	48289	4830	4838	*01145	48230
48282	48283	48289	4830	4838	*01140	48230	48231
48283	48289	4830	4838	*01132	48230	48231	48232
48289	4830	4838	*01124	48230	48231	48232	48239
4830	4838	*01116	48230	48231	48232	48239	48281
4838	*01111	48230	48231	48232	48239	48281	48282
*01103	48230	48231	48232	48239	48281	48282	48283
48230	48231	48232	48239	48281	48282	48283	48289
48231	48232	48239	48281	48282	48283	48289	4830
48232	48239	48281	48282	48283	48289	4830	4838
48239	48281	48282	48283	48289	4830	4838	*01154
48281	48282	48283	48289	4830	4838	*01146	48230
48282	48283	48289	4830	4838	*01141	48230	48231
48283	48289	4830	4838	*01133	48230	48231	48232
48289	4830	4838	*01125	48230	48231	48232	48239
4830	4838	*01120	48230	48231	48232	48239	48281
4838	*01112	48230	48231	48232	48239	48281	48282
*01104	48230	48231	48232	48239	48281	48282	48283
48230	48231	48232	48239	48281	48282	48283	48289
48231	48232	48239	48281	48282	48283	48289	4830
48232	48239	48281	48282	48283	48289	4830	4838
48239	48281	48282	48283	48289	4830	4838	*01155
48281	48282	48283	48289	4830	4838	*01150	48230
48282	48283	48289	4830	4838	*01142	48230	48231
48283	48289	4830	4838	*01134	48230	48231	48232

48239	48281	48282	48283	48289	4830	4838	*01206
48281	48282	48283	48289	4830	4838	*01201	48230
48282	48283	48289	4830	4838	*01193	48230	48231
48283	48289	4830	4838	*01185	48230	48231	48232
48289	4830	4838	*01180	48230	48231	48232	48239
4830	4838	*01172	48230	48231	48232	48239	48281
4838	*01164	48230	48231	48232	48239	48281	48282
*01156	48230	48231	48232	48239	48281	48282	48283
48230	48231	48232	48239	48281	48282	48283	48289
48231	48232	48239	48281	48282	48283	48289	4830
48232	48239	48281	48282	48283	48289	4830	4838
48239	48281	48282	48283	48289	4830	4838	*01210
48281	48282	48283	48289	4830	4838	*01202	48230
48282	48283	48289	4830	4838	*01194	48230	48231
48283	48289	4830	4838	*01186	48230	48231	48232
48289	4830	4838	*01181	48230	48231	48232	48239
4830	4838	*01173	48230	48231	48232	48239	48281
4838	*01165	48230	48231	48232	48239	48281	48282
*01160	48230	48231	48232	48239	48281	48282	48283
48230	48231	48232	48239	48281	48282	48283	48289
48231	48232	48239	48281	48282	48283	48289	4830
48232	48239	48281	48282	48283	48289	4830	4838
48239	48281	48282	48283	48289	4830	4838	*01211
48281	48282	48283	48289	4830	4838	*01203	48230
48282	48283	48289	4830	4838	*01195	48230	48231
48283	48289	4830	4838	*01190	48230	48231	48232
48289	4830	4838	*01182	48230	48231	48232	48239
4830	4838	*01174	48230	48231	48232	48239	48281
4838	*01166	48230	48231	48232	48239	48281	48282
*01161	48230	48231	48232	48239	48281	48282	48283
48230	48231	48232	48239	48281	48282	48283	48289
48231	48232	48239	48281	48282	48283	48289	4830
48232	48239	48281	48282	48283	48289	4830	4838
48239	48281	48282	48283	48289	4830	4838	*01212
48281	48282	48283	48289	4830	4838	*01204	48230
48282	48283	48289	4830	4838	*01196	48230	48231
48283	48289	4830	4838	*01191	48230	48231	48232
48289	4830	4838	*01183	48230	48231	48232	48239
4830	4838	*01175	48230	48231	48232	48239	48281
4838	*01170	48230	48231	48232	48239	48281	48282
*01162	48230	48231	48232	48239	48281	48282	48283
48230	48231	48232	48239	48281	48282	48283	48289
48231	48232	48239	48281	48282	48283	48289	4830
48232	48239	48281	48282	48283	48289	4830	4838
48239	48281	48282	48283	48289	4830	4838	*01213
48281	48282	48283	48289	4830	4838	*01205	48230
48282	48283	48289	4830	4838	*01200	48230	48231
48283	48289	4830	4838	*01192	48230	48231	48232
48289	4830	4838	*01184	48230	48231	48232	48239
4830	4838	*01176	48230	48231	48232	48239	48281
4838	*01171	48230	48231	48232	48239	48281	48282
*01163	48230	48231	48232	48239	48281	48282	48283
48230	48231	48232	48239	48281	48282	48283	48289
48231	48232	48239	48281	48282	48283	48289	4830
48232	48239	48281	48282	48283	48289	4830	4838
48239	48281	48282	48283	48289	4830	4838	*01214

48230	48231	32089	48232	48239	0380	6822	6804
48231	48232	*01301	48239	48281	0381	6823	6805
48232	48239	32081	48281	48282	0382	6825	6806
48239	48281	32082	48282	48283	0383	6826	6807
48281	48282	32089	48283	48289	03840	6827	6808
48282	48283	*01302	48289	4830	03841	6828	6809
48283	48289	32081	4830	4838	03842	6829	6820
48289	4830	32082	4838	*01796	03843	*04102	6821
4830	4838	32089	*01791	48230	03844	0380	6822
4838	*01283	*01303	48230	48231	03849	0381	6823
*01215	48230	32081	48231	48232	0388	0382	6825
48230	48231	32082	48232	48239	0389	0383	6826
48231	48232	32089	48239	48281	6800	03840	6827
48232	48239	*01304	48281	48282	6801	03841	6828
48239	48281	32081	48282	48283	6802	03842	6829
48281	48282	32082	48283	48289	6803	03843	*04104
48282	48283	32089	48289	4830	6804	03844	0380
48283	48289	*01305	4830	4838	6805	03849	0381
48289	4830	32081	4838	*0212	6806	0388	0382
4830	4838	32082	*01792	48230	6807	0389	0383
4838	*01284	32089	48230	48231	6808	6800	03840
*01216	48230	*01306	48231	48232	6809	6801	03841
48230	48231	32081	48232	48239	6820	6802	03842
48231	48232	32082	48239	48281	6821	6803	03843
48232	48239	32089	48281	48282	6822	6804	03844
48239	48281	*01310	48282	48283	6823	6805	03849
48281	48282	32081	48283	48289	6825	6806	0388
48282	48283	32082	48289	4830	6826	6807	0389
48283	48289	32089	4830	4838	6827	6808	6800
48289	4830	*01311	4838	*0310	6828	6809	6801
4830	4838	32081	*01793	48230	6829	6820	6802
4838	*01285	32082	48230	48231	*04101	6821	6803
*01280	48230	32089	48231	48232	0380	6822	6804
48230	48231	*01312	48232	48239	0381	6823	6805
48231	48232	32081	48239	48281	0382	6825	6806
48232	48239	32082	48281	48282	0383	6826	6807
48239	48281	32089	48282	48283	03840	6827	6808
48281	48282	*01313	48283	48289	03841	6828	6809
48282	48283	32081	48289	4830	03842	6829	6820
48283	48289	32082	4830	4838	03843	*04103	6821
48289	4830	32089	4838	*0360	03844	0380	6822
4830	4838	*01314	*01794	32081	03849	0381	6823
4838	*01286	32081	48230	32082	0388	0382	6825
*01281	48230	32082	48231	32089	0389	0383	6826
48230	48231	32089	48232	*0391	6800	03840	6827
48231	48232	*01315	48239	48230	6801	03841	6828
48232	48239	32081	48281	48231	6802	03842	6829
48239	48281	32082	48282	48232	6803	03843	*04105
48281	48282	32089	48283	48239	6804	03844	0380
48282	48283	*01316	48289	48281	6805	03849	0381
48283	48289	32081	4830	48282	6806	0388	0382
48289	4830	32082	4838	48283	6807	0389	0383
4830	4838	32089	*01795	48289	6808	6800	03840
4838	*01300	*01790	48230	4830	6809	6801	03841
*01282	32081	48230	48231	4838	6820	6802	03842
48230	32082	48231	48232	*04100	6821	6803	03843

03844	0380	6822	01122	01203	01363	01634	01744
03849	0381	6823	01123	01204	01364	01635	01745
0388	0382	6825	01124	01205	01365	01636	01746
0389	0383	6826	01125	01206	01366	01640	01750
6800	03840	6827	01126	01210	01380	01641	01751
6801	03841	6828	01130	01211	01381	01642	01752
6802	03842	6829	01131	01212	01382	01643	01753
6803	03843	*04119	01132	01213	01383	01644	01754
6804	03844	0380	01133	01214	01384	01645	01755
6805	03849	0381	01134	01215	01385	01646	01756
6806	0388	0382	01135	01216	01386	01650	01760
6807	0389	0383	01136	01300	01390	01651	01761
6808	6800	03840	01140	01301	01391	01652	01762
6809	6801	03841	01141	01302	01392	01653	01763
6820	6802	03842	01142	01303	01393	01654	01764
6821	6803	03843	01143	01304	01394	01655	01765
6822	6804	03844	01144	01305	01395	01656	01766
6823	6805	03849	01145	01306	01396	01660	01770
6825	6806	0388	01146	01310	01400	01661	01771
6826	6807	0389	01150	01311	01401	01662	01772
6827	6808	6800	01151	01312	01402	01663	01773
6828	6809	6801	01152	01313	01403	01664	01774
6829	6820	6802	01153	01314	01404	01665	01775
*04109	6821	6803	01154	01315	01405	01666	01776
0380	6822	6804	01155	01316	01406	01670	01780
0381	6823	6805	01156	01320	01480	01671	01781
0382	6825	6806	01160	01321	01482	01672	01782
0383	6826	6807	01161	01322	01483	01673	01783
03840	6827	6808	01162	01323	01484	01674	01784
03841	6828	6809	01163	01324	01485	01675	01785
03842	6829	6820	01164	01325	01486	01676	01786
03843	*04111	6821	01165	01326	01600	01690	01790
03844	0380	6822	01170	01330	01601	01691	01791
03849	0381	6823	01171	01331	01602	01692	01792
0388	0382	6825	01172	01332	01603	01693	01793
0389	0383	6826	01173	01333	01604	01694	01794
6800	03840	6827	01174	01334	01605	01695	01795
6801	03841	6828	01175	01335	01606	01696	01796
6802	03842	6829	01176	01336	01610	01720	01800
6803	03843	*04181	01180	01340	01611	01721	01801
6804	03844	01100	01181	01341	01612	01722	01802
6805	03849	01101	01182	01342	01613	01723	01803
6806	0388	01102	01183	01343	01614	01724	01804
6807	0389	01103	01184	01344	01615	01725	01805
6808	6800	01104	01185	01345	01616	01726	01806
6809	6801	01105	01186	01346	01620	01730	01880
6820	6802	01106	01190	01350	01621	01731	01881
6821	6803	01110	01191	01351	01622	01732	01882
6822	6804	01111	01192	01352	01623	01733	01883
6823	6805	01112	01193	01353	01624	01734	01884
6825	6806	01113	01194	01354	01625	01735	01885
6826	6807	01114	01195	01355	01626	01736	01886
6827	6808	01115	01196	01356	01630	01740	01890
6828	6809	01116	01200	01360	01631	01741	01891
6829	6820	01120	01201	01361	01632	01742	01892
*04110	6821	01121	01202	01362	01633	01743	01893

01894	01110	01191	01351	01622	01732	01882	6829
01895	01111	01192	01352	01623	01733	01883	*04183
01896	01112	01193	01353	01624	01734	01884	01100
0310	01113	01194	01354	01625	01735	01885	01101
0360	01114	01195	01355	01626	01736	01886	01102
0361	01115	01196	01356	01630	01740	01890	01103
0362	01116	01200	01360	01631	01741	01891	01104
0363	01120	01201	01361	01632	01742	01892	01105
03640	01121	01202	01362	01633	01743	01893	01106
03641	01122	01203	01363	01634	01744	01894	01110
03642	01123	01204	01364	01635	01745	01895	01111
03643	01124	01205	01365	01636	01746	01896	01112
03681	01125	01206	01366	01640	01750	0310	01113
03682	01126	01210	01380	01641	01751	0360	01114
03689	01130	01211	01381	01642	01752	0361	01115
0369	01131	01212	01382	01643	01753	0362	01116
0380	01132	01213	01383	01644	01754	0363	01120
0381	01133	01214	01384	01645	01755	03640	01121
0382	01134	01215	01385	01646	01756	03641	01122
0383	01135	01216	01386	01650	01760	03642	01123
03840	01136	01300	01390	01651	01761	03643	01124
03841	01140	01301	01391	01652	01762	03681	01125
03842	01141	01302	01392	01653	01763	03682	01126
03843	01142	01303	01393	01654	01764	03689	01130
03844	01143	01304	01394	01655	01765	0369	01131
03849	01144	01305	01395	01656	01766	0380	01132
0388	01145	01306	01396	01660	01770	0381	01133
0389	01146	01310	01400	01661	01771	0382	01134
3570	01150	01311	01401	01662	01772	0383	01135
6800	01151	01312	01402	01663	01773	03840	01136
6801	01152	01313	01403	01664	01774	03841	01140
6802	01153	01314	01404	01665	01775	03842	01141
6803	01154	01315	01405	01666	01776	03843	01142
6804	01155	01316	01406	01670	01780	03844	01143
6805	01156	01320	01480	01671	01781	03849	01144
6806	01160	01321	01482	01672	01782	0388	01145
6807	01161	01322	01483	01673	01783	0389	01146
6808	01162	01323	01484	01674	01784	3570	01150
6809	01163	01324	01485	01675	01785	6800	01151
6820	01164	01325	01486	01676	01786	6801	01152
6821	01165	01326	01600	01690	01790	6802	01153
6822	01170	01330	01601	01691	01791	6803	01154
6823	01171	01331	01602	01692	01792	6804	01155
6825	01172	01332	01603	01693	01793	6805	01156
6826	01173	01333	01604	01694	01794	6806	01160
6827	01174	01334	01605	01695	01795	6807	01161
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6829	01176	01336	01610	01720	01800	6809	01163
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01183	01343	01614	01724	01804	6823	01171	01331
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01203	01363	01634	01744	01894	01110	01191	01351
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03844	01144	01305	01395	01656	01766	0380	*07030
03849	01145	01306	01396	01660	01770	0381	7800
0388	01146	01310	01400	01661	01771	0382	*07031
0389	01150	01311	01401	01662	01772	0383	7800
6800	01151	01312	01402	01663	01773	03840	*07041
6801	01152	01313	01403	01664	01774	03841	7800
6802	01153	01314	01404	01665	01775	03842	*07042
6803	01154	01315	01405	01666	01776	03843	7800
6804	01155	01316	01406	01670	01780	03844	*07043
6805	01156	01320	01480	01671	01781	03849	7800
6806	01160	01321	01482	01672	01782	0388	*07049
6807	01161	01322	01483	01673	01783	0389	7800
6808	01162	01323	01484	01674	01784	3570	*07051
6809	01163	01324	01485	01675	01785	6800	7800
6820	01164	01325	01486	01676	01786	6801	*07052
6821	01165	01326	01600	01690	01790	6802	7800
6822	01170	01330	01601	01691	01791	6803	*07053
6823	01171	01331	01602	01692	01792	6804	7800
6825	01172	01332	01603	01693	01793	6805	*07059
6826	01173	01333	01604	01694	01794	6806	7800
6827	01174	01334	01605	01695	01795	6807	*0706
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6829	01176	01336	01610	01720	01800	6809	*0709
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01100	01181	01341	01612	01722	01802	6821	*0721
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01102	01183	01343	01614	01724	01804	6823	*09042

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*09181	*11515	*25071	11511	*431	01114	01194	5081
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*0942	4828	*25080	3200	*4320	01116	01196	*4824
3208	483	3208	3201	7800	01120	01200	4823
*09889	*11591	7800	3202	*4321	01121	01201	4828
3208	3208	*25081	3203	7800	01122	01202	483
*0994	*11595	3208	3207	*4329	01123	01203	*4828
09040	4823	7800	3208	7800	01124	01204	01100
09041	4828	*25090	3209	*4800	01125	01205	01101
09042	483	3208	3210	4823	01126	01206	01102
09049	*1221	7800	3211	4828	01130	01210	01103
0930	4823	*25091	3212	483	01131	01211	01104
0931	4828	3208	3213	*4801	01132	01212	01105
09320	483	7800	3214	4823	01133	01213	01106
09321	*1300	*2510	3218	4828	01134	01214	01110
09322	3208	7800	3220	483	01135	01215	01111
09323	*1304	*2511	3221	*4802	01136	01216	01112
09324	4823	7800	3222	4823	01140	0310	01113
09381	4828	*2512	3229	4828	01141	11505	01114
09382	483	7800	3570	483	01142	11515	01115
09389	*1363	*2513	*3209	*4808	01143	1304	01116
0939	4823	7800	3208	4823	01144	1363	01120
0940	4828	*3200	*3210	4828	01145	481	01121
0941	483	3208	3208	483	01146	4820	01122
0942	*25000	*3201	*3211	*4809	01150	4821	01123
0943	7800	3208	3208	4823	01151	4822	01124
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09813	*25021	01301	*3220	4828	01163	4846	01136
09814	7800	01302	3208	483	01164	4847	01140
09815	*25030	01303	*3221	*4821	01165	4848	01141
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09817	*25031	01305	*3222	4828	01170	486	01143
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*10081	*25041	01312	*3488	4828	01174	4952	01150
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*11283	*25050	01314	*3489	*4823	01176	4954	01152
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4828	3208	0942	*3570	01110	01190	5070	01163
483	7800	11283	3208	01111	01191	5071	01164
*11511	*25070	1142	*430	01112	01192	5078	01165

01166	485	01142	11515	4823	4823	4823	7800
01170	486	01143	1304	4828	4828	4828	*5965
01171	4870	01144	1363	483	483	483	5960
01172	4950	01145	481	*4848	*4958	*5069	5964
01173	4951	01146	4820	4823	4823	4823	5996
01174	4952	01150	4821	4828	4828	4828	7882
01175	4953	01151	4822	483	483	483	*5998
01176	4954	01152	4823	*485	*4959	*5070	5800
01180	4955	01153	4824	4823	4823	4823	5804
01181	4956	01154	4828	4828	4828	4828	58081
01182	4957	01155	4829	483	483	483	58089
01183	4958	01156	483	*486	*496	*5071	5809
01184	4959	01160	4841	4823	4823	4823	5810
01185	5060	01161	4843	4828	4828	4828	5811
01186	5061	01162	4845	483	483	483	5812
01190	5070	01163	4846	*4870	*500	*5078	5813
01191	5071	01164	4847	4823	4823	4823	58181
01192	5078	01165	4848	4828	4828	4828	58189
01193	5080	01166	485	483	483	483	5819
01194	5081	01170	486	*4871	*501	*5080	5834
01195	5171	01171	4870	4823	4823	4823	5845
01196	*4829	01172	4950	4828	4828	4828	5846
01200	4823	01173	4951	483	483	483	5847
01201	4828	01174	4952	*494	*502	*5081	5848
01202	483	01175	4953	4823	4823	4823	5849
01203	*483	01176	4954	4828	4828	4828	585
01204	01100	01180	4955	483	483	483	59010
01205	01101	01181	4956	*4950	*503	*5088	59011
01206	01102	01182	4957	4823	4823	4823	5902
01210	01103	01183	4958	4828	4828	4828	5903
01211	01104	01184	4959	483	483	483	59080
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01213	01106	01186	5061	4823	4823	4823	5909
01214	01110	01190	5070	4828	4828	4828	591
01215	01111	01191	5071	483	483	483	5921
01216	01112	01192	5078	*4952	*505	*5171	5935
0310	01113	01193	5080	4823	4823	4823	5950
11505	01114	01194	5081	4828	4828	4828	5951
11515	01115	01195	5171	483	483	483	5952
1304	01116	01196	*4841	*4953	*5060	*5178	5954
1363	01120	01200	4823	4823	4823	4823	59581
481	01121	01201	4828	4828	4828	4828	59582
4820	01122	01202	483	483	483	483	59589
4821	01123	01203	*4843	*4954	*5061	*51889	5959
4822	01124	01204	4823	4823	4823	4823	5961
4823	01125	01205	4828	4828	4828	4828	5962
4824	01126	01206	483	483	483	483	5964
4828	01130	01210	*4845	*4955	*5062	*5198	5966
4829	01131	01211	4823	4823	4823	4823	5967
483	01132	01212	4828	4828	4828	4828	5970
4841	01133	01213	483	483	483	483	5981
4843	01134	01214	*4846	*4956	*5063	*5199	5982
4845	01135	01215	4823	4823	4823	4823	5990
4846	01136	01216	4828	4828	4828	4828	5994
4847	01140	0310	483	483	483	483	5996
4848	01141	11505	*4847	*4957	*5064	*5722	5997

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4828	7800	7800	7800	7800	7800	7800	7800
483	*80024	*80060	*90094	*80130	*80164	*80300	*80334
*7800	7800	7800	7800	7800	7800	7800	7800
430	*80025	*80061	*80095	*80131	*80165	*80301	*80335
431	7800	7800	7800	7800	7800	7800	7800
4320	*80026	*80062	*80096	*80132	*80166	*80302	*80336
4321	7800	7800	7800	7800	7800	7800	7800
436	*80029	*80063	*80099	*80133	*80169	*80303	*80339
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*7809	*80032	*80066	*80102	*80136	*80172	*80306	*80342
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*80003	*80039	*80073	*80109	*80143	*80179	*80313	*80349
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*80004	*80040	*80074	*80110	*80144	*80180	*80314	*80350
7800	7800	7800	7800	7800	7800	7800	7800
*80005	*80041	*80075	*80111	*80145	*80181	*80315	*80351
7800	7800	7800	7800	7800	7800	7800	7800
*80006	*80042	*80076	*80112	*80146	*80182	*80316	*80352
7800	7800	7800	7800	7800	7800	7800	7800
*80009	*80043	*80079	*80113	*80149	*80183	*80319	*80353
7800	7800	7800	7800	7800	7800	7800	7800
*80010	*80044	*80080	*80114	*80150	*80184	*80320	*80354
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*80011	*80045	*80081	*80115	*80151	*80185	*80321	*80355
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7800	7800	7800	7800	7800	7800	7800	7800
*80014	*80050	*80084	*80120	*80154	*80190	*80324	*80360
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7800	7800	7800	7800	7800	7800	7800	7800
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7800	7800	7800	7800	7800	7800	7800	7800
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7800	7800	7800	7800	7800	7800	7800	7800
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*80396	*80432	*80466	*8503	*85130	*85164	*85200	*85235
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*80399	*80433	*80469	*8504	*85131	*85165	*85201	*85236
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TABLE 7A - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 12/91 GROUPEL V9.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
001	28268	15.7441	4	7	11	19	31
002	5716	14.9003	4	7	11	19	30
003	3	2.0000	1	1	1	4	4
004	5127	13.0521	3	5	9	18	27
005	52807	6.7496	2	3	5	8	13
006	854	3.3162	1	1	2	3	7
007	5742	21.2179	2	6	11	22	45
008	2699	4.5954	1	1	3	8	10
009	1678	10.5864	2	4	7	12	21
010	19835	10.8720	2	4	7	14	22
011	3528	6.4212	1	2	4	8	13
012	21359	10.4106	2	4	7	12	19
013	5571	8.5144	3	4	7	10	15
014	337593	9.9669	3	4	7	12	19
015	133891	5.4328	2	3	4	6	10
016	11011	9.3524	3	4	7	11	18
017	2982	5.7667	2	3	5	7	10
018	13605	7.9338	2	4	6	9	15
019	6848	5.4936	1	2	4	7	11
020	7404	12.4114	2	5	9	16	25
021	1006	9.6928	3	4	7	12	19
022	8691	5.5158	2	3	4	7	10
023	3067	6.2097	1	2	4	7	12
024	53265	7.3423	2	3	5	9	14
025	22480	4.4321	1	2	3	5	8
026	55	5.6727	1	2	3	5	8
027	2678	7.9623	1	2	3	5	8
028	7878	9.4439	2	3	4	6	10
029	3540	4.8621	1	2	3	5	8
030	2	1.0000	1	1	1	1	1
031	3572	6.6249	2	2	4	7	13
032	2583	3.6806	1	2	3	4	7
034	13461	8.8028	2	3	6	10	17
035	3768	5.2606	1	2	4	6	10
036	20229	2.3422	1	1	2	3	4
037	2665	4.4649	1	1	2	3	5
038	770	2.8208	1	1	2	3	5
039	9581	1.9363	1	1	2	2	3
040	3321	3.4192	1	1	2	2	3
042	20297	2.5528	1	1	2	2	3
043	201	5.6866	1	2	4	6	11
044	1962	6.2819	2	4	5	7	11
045	2588	4.4532	1	2	4	6	8
046	2876	6.2827	1	2	4	6	8
047	1859	4.4330	1	2	4	5	8
048	2	7.0000	5	5	9	9	15
049	2967	7.6923	2	3	5	9	15
050	4902	2.6391	1	1	2	3	4
051	524	2.8645	1	1	2	3	4
052	171	3.1462	1	1	2	3	4
053	6387	3.4481	1	1	2	3	4

TABLE 7A - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 12/91 GROUPER V9.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
055	3589	2.7317	1	1	1	2	6
056	1090	2.7009	1	1	1	3	6
057	696	5.3750	1	2	3	6	11
058	1	1.0000	1	1	1	1	1
059	183	2.1858	1	1	1	2	4
061	381	5.0919	1	1	2	6	12
063	4780	5.7492	1	2	4	7	12
064	4332	8.7652	1	2	5	11	20
065	32014	4.1498	1	2	3	5	8
066	7733	4.3419	1	2	3	5	8
067	425	5.1671	2	2	3	5	9
068	11536	5.9536	2	3	4	5	11
069	3729	4.3124	2	2	3	5	8
070	17	4.5294	1	2	3	5	9
071	132	5.0682	2	2	3	5	10
072	873	5.7281	1	2	3	5	9
073	6546	5.0053	1	2	3	5	10
074	2	11.0000	1	2	3	5	12
075	31753	13.7042	9	8	10	13	13
076	75078	14.3224	6	7	11	18	25
077	6545	7.5325	4	7	10	18	27
078	26477	10.0135	1	3	8	10	15
079	132677	11.6036	4	7	9	12	18
080	8940	7.7613	4	6	9	14	21
081	1	7.0000	3	7	8	9	14
082	58814	9.0936	7	7	7	7	7
083	7021	8.1493	2	4	7	12	19
084	1783	4.4577	2	4	6	10	15
085	16869	8.8759	1	4	6	8	8
086	1697	5.2787	2	4	7	11	17
087	81021	8.0394	2	4	7	10	10
088	161966	7.3437	3	4	6	9	15
089	368544	8.6408	3	5	7	10	13
090	45578	6.1821	3	4	6	9	15
091	44	6.1136	3	4	7	10	10
092	8321	8.5321	3	4	7	10	11
093	1327	5.8425	2	3	5	7	10
094	9350	9.3702	3	4	7	11	18
095	1287	5.3963	3	3	4	7	10
096	178236	7.0607	3	4	6	8	12
097	32075	5.1441	3	3	4	6	8
098	17	6.2941	2	3	4	6	8
099	30114	5.1423	2	2	3	4	6
100	11199	3.1203	1	2	2	3	6
101	18008	6.6578	2	2	3	4	6
102	3535	4.2795	2	2	3	4	6
103	238	32.1723	1	1	2	3	5
104	17372	20.2585	10	14	23	38	62
105	15979	14.4294	9	12	17	25	35
106	74580	15.2254	7	9	11	16	24
107	52388	11.7506	8	10	13	17	25

TABLE 7A - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 12/91 GROUPER V9.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
108	8815	15.1239	7	9	12	18	27
110	50710	13.4182	3	8	11	18	25
111	6320	8.4108	3	6	8	10	13
112	128899	6.0896	2	3	5	8	12
113	36405	18.7793	6	8	14	22	37
114	8076	12.4459	3	5	8	15	24
115	8203	13.8516	5	8	11	17	24
116	63412	7.2544	2	3	6	9	14
117	3265	5.5103	1	2	3	7	12
118	8177	3.9209	1	1	2	4	8
119	3204	6.2644	1	2	3	7	15
120	34531	12.1610	2	3	8	15	27
121	143327	9.6028	4	6	8	11	18
122	99268	6.8777	2	4	7	9	11
123	55036	5.2961	1	1	3	7	13
124	123627	5.7604	1	2	3	5	11
125	88564	3.1515	1	1	2	4	7
126	4203	20.4149	5	10	16	29	41
127	602239	7.7143	2	4	7	9	14
128	23149	8.4066	4	5	7	10	13
129	6227	4.7466	1	1	1	6	12
130	70683	8.0792	2	4	7	10	14
131	26293	5.9826	1	3	6	8	10
132	12691	5.5565	1	2	4	7	11
133	4152	3.9188	1	2	3	5	7
134	29005	4.9912	2	2	3	6	9
135	6404	6.6284	2	3	5	8	13
136	1428	4.3690	1	2	3	5	7
138	185487	5.8414	2	3	4	7	11
139	71704	3.6838	1	2	3	5	8
140	341502	4.4690	2	2	3	5	10
141	76370	5.6764	2	3	4	7	10
142	36764	3.9269	1	2	3	5	8
143	115719	3.3746	1	2	3	5	7
144	55652	7.0829	2	3	5	8	14
145	8435	4.1801	1	2	3	5	8
146	7565	13.7870	7	9	11	15	22
147	1620	8.9846	5	7	9	11	13
148	141393	15.8461	7	9	12	18	28
149	18120	9.0679	6	7	8	10	13
150	21587	13.8921	5	8	11	17	24
151	4781	7.7833	3	4	7	10	13
152	4551	10.6339	5	7	9	12	18
153	2048	7.0459	4	5	7	10	13
154	37035	17.9293	7	9	14	22	34
155	4178	8.6084	4	5	7	10	13
157	13128	6.5957	2	3	5	8	12
158	9959	3.0688	1	1	2	4	6
159	16227	6.3665	2	3	5	8	12
160	12821	3.3392	1	2	3	4	6
161	23791	4.6269	1	2	3	4	6

TABLE 7A - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 12/91 GROUPER V9.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
162	21101	2.2025	1	1	2	3	4
163	10	2.4000	1	2	2	3	4
164	4579	11.3872	5	7	9	13	19
165	1794	7.0284	4	5	9	9	11
166	2932	7.1538	3	4	6	9	13
167	2170	4.1253	2	3	4	5	7
168	1799	5.7943	2	3	4	5	7
169	1366	2.9129	1	2	3	3	6
170	12713	15.6310	3	7	11	18	31
171	1483	6.9412	1	3	6	9	13
172	31140	10.3381	2	4	7	13	21
173	3337	5.2517	1	2	4	7	11
174	165016	6.9276	2	4	5	8	13
175	22542	4.3682	2	3	4	5	7
176	12892	7.7026	2	4	5	9	14
177	14855	6.2788	2	3	5	8	11
178	6418	4.4483	2	3	4	5	8
179	8630	9.5102	3	4	6	11	18
180	69302	7.6203	2	4	7	9	14
181	22049	4.5862	2	3	4	6	8
182	256259	6.2255	2	3	4	7	11
183	78178	4.5400	1	2	4	5	8
184	50	3.6000	1	2	3	4	6
185	3831	6.3156	1	3	5	8	13
186	1	4.0000	1	4	4	4	4
187	987	3.9529	1	1	2	5	8
188	49808	7.3748	2	3	5	9	14
189	9043	3.8545	1	3	3	5	8
190	94	5.2447	2	3	3	7	10
191	10080	19.7739	6	10	15	24	39
192	985	9.6020	3	6	8	12	16
193	12295	16.5587	7	9	14	20	29
194	1416	9.7041	3	6	9	12	17
195	17110	12.2889	6	7	10	14	20
196	1856	8.2193	4	5	7	10	13
197	76376	8.4937	4	4	7	11	16
198	48653	3.6350	1	1	3	5	7
199	2829	14.2616	4	7	11	18	27
200	1923	13.5190	2	5	10	17	28
201	2997	14.3784	3	6	10	18	30
202	17745	9.6320	2	4	7	12	20
203	29497	9.7206	2	4	7	12	20
204	39199	8.0600	3	4	7	9	15
205	20814	9.1418	2	4	6	9	15
206	2413	5.0220	1	2	4	7	10
207	37528	7.0338	2	2	4	7	10
208	14008	4.0415	1	2	4	5	7
209	267627	10.5536	6	7	9	12	16
210	116591	12.9940	6	8	10	14	21
211	28911	9.4425	5	8	10	14	21
212	18	6.1111	2	2	3	7	9

TABLE 7A - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 12/91 GROUPER V9.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
213	5738	12.8313	3	6	9	16	25
214	41313	10.2321	4	5	8	12	18
215	37991	6.0854	3	4	5	7	10
216	7018	14.4741	3	6	11	18	28
217	18528	21.0197	4	7	14	27	45
218	18336	9.0046	3	4	7	11	17
219	17781	5.1599	2	3	4	4	9
220	2.500	2.2500	1	1	2	3	3
221	4858	10.7091	2	4	8	13	21
222	5229	5.2878	1	2	4	7	10
223	15713	4.0320	1	2	3	4	7
224	8728	2.8997	1	2	2	4	7
225	9983	5.2825	1	2	3	3	5
226	5452	8.9762	2	3	3	6	12
227	6465	3.8863	1	2	3	4	20
228	4327	3.7123	1	1	2	4	7
229	2505	2.5591	1	1	2	4	8
230	3230	6.4412	1	2	2	3	5
231	10173	6.5634	1	2	4	7	15
232	793	6.5523	1	2	3	7	23
233	5188	11.8795	3	5	9	15	23
234	3023	5.4016	1	2	4	7	11
235	6239	11.1856	2	4	7	12	23
236	38320	8.9087	2	4	7	10	17
237	1981	5.8257	2	3	7	7	10
238	6361	13.9027	4	6	10	17	28
239	59318	10.0120	3	5	10	12	19
240	10920	9.3950	3	4	7	11	18
241	3950	5.6463	2	3	4	7	11
242	2488	10.5086	3	5	8	13	22
243	103841	6.8288	2	3	5	9	13
244	11051	7.2525	2	3	5	9	14
245	5661	5.3374	1	2	4	8	10
246	1726	5.4177	2	3	4	7	10
247	9689	5.0789	1	2	4	6	10
248	6248	6.1908	2	3	5	7	12
249	8359	6.3973	2	3	5	8	12
250	3393	6.7781	2	3	5	8	12
251	3237	3.6256	1	1	2	4	7
253	16958	8.1943	2	3	6	9	16
254	12121	4.7225	1	2	3	5	9
255	2	2.5000	1	1	2	3	4
256	9233	5.4512	1	2	4	6	11
257	28219	5.1278	2	3	4	6	9
258	26390	3.6482	2	2	3	4	6
259	4004	5.9288	1	2	3	4	6
260	4978	2.5700	1	1	2	3	4
261	2941	2.8259	1	1	2	3	4
262	1302	3.5661	1	1	2	3	4
263	28743	20.2119	5	8	14	24	40
264	4186	11.3512	3	5	9	14	23

TABLE 7A - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 12/91 GROUPER V9.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
265	4915	9.6867	2	3	6	11	21
266	4167	4.3252	1	2	3	5	9
267	368	4.9837	1	1	3	5	11
268	1410	5.1723	1	1	2	5	9
269	10906	12.2327	2	4	9	15	25
270	5130	4.0310	1	2	3	5	9
271	19866	11.4729	3	5	8	13	21
272	93836	8.8090	3	5	7	11	18
273	2194	10.9341	2	3	5	8	14
274	3139	5.7232	2	4	7	12	21
275	401	5.7151	1	2	3	6	9
276	867	8.4681	1	2	4	7	11
277	70657	6.1614	3	5	7	10	15
278	25890	7.0000	3	4	5	7	11
279	6	6.7166	2	3	4	7	11
280	12914	4.1994	2	3	3	5	8
281	7188	2.0000	1	2	2	2	2
282	1	7.3003	2	3	2	5	8
283	5814	5.0682	2	3	4	6	14
284	2389	20.6736	1	2	4	6	8
285	4549	11.2702	5	9	15	25	40
286	1721	18.7138	4	7	12	21	38
287	6493	10.4694	3	4	7	10	21
288	507	5.6718	2	2	3	5	12
289	3955	3.4522	1	2	2	4	6
290	9577	2.1049	1	1	2	2	4
291	143	17.6921	4	7	13	21	35
292	5044	7.4950	1	3	6	10	15
293	505	7.2549	3	4	6	7	11
294	89720	5.8483	2	3	4	6	10
295	3262	8.3160	2	3	4	6	10
296	210976	5.1711	2	3	4	6	10
297	44441	4.6308	1	2	3	5	9
298	65	6.5530	1	2	3	5	9
299	877	9.3115	3	4	5	8	13
300	11785	5.2160	1	2	4	7	11
301	2074	15.9463	7	9	13	19	28
302	6613	13.2953	6	8	10	15	23
303	17481	13.3842	4	6	8	12	17
304	13876	6.4578	2	3	4	6	10
305	3517	8.8255	3	4	6	8	12
306	12341	4.5686	2	3	4	6	10
307	4325	9.0454	2	3	4	6	10
308	10288	3.9877	1	2	3	5	9
309	4383	5.6127	1	2	3	5	9
310	35212	2.6869	1	1	2	3	5
311	19528	5.5239	1	1	2	3	5
312	3102	2.7629	1	1	2	3	5
313	1818	8.0000	8	8	8	8	8
314	1	12.2125	1	3	7	15	27
315	26943						

TABLE 7A - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 12/91 GROUPER V9.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
316	49088	9.1386	2	4	7	12	18
317	707	4.1782	1	2	3	4	8
318	6661	8.9922	2	3	6	11	19
319	884	3.7986	1	1	2	4	8
320	162684	8.3690	3	4	6	10	15
321	29134	5.8757	2	3	5	7	10
322	50	5.8400	2	3	5	7	10
323	20541	4.2749	1	2	3	5	9
324	13479	2.5819	1	1	2	3	5
325	9618	5.7660	2	3	4	7	11
326	3608	3.5658	1	2	3	4	7
327	8	7.0000	1	2	3	4	7
328	1257	4.9578	1	2	3	4	7
329	341	2.9003	1	1	2	3	5
331	29323	7.4644	2	3	5	9	15
332	5847	4.4404	1	2	3	4	9
333	311	7.5948	2	3	5	9	15
334	22366	9.1218	2	3	5	9	15
335	10820	7.2789	5	8	10	14	18
336	105208	5.7983	3	6	8	10	14
337	88453	3.8239	2	3	4	7	10
338	7448	5.2254	1	2	3	4	6
339	3230	4.6889	1	1	2	3	6
340	2	5.0000	3	3	7	7	11
341	12838	4.3805	1	2	3	5	8
342	410	3.8610	1	1	2	3	7
343	2	2.0000	1	1	2	3	8
344	4825	5.3988	1	2	3	4	9
345	2512	4.8949	1	2	3	4	10
346	7797	8.5775	2	3	6	10	17
347	963	4.3894	1	1	3	5	10
348	4269	5.7126	1	2	3	4	11
349	1634	3.1157	1	1	2	3	6
350	7998	5.8718	2	3	5	7	10
351	1	5.0000	6	6	8	8	10
352	770	4.8085	1	2	3	4	10
353	2321	11.4942	5	6	9	14	21
354	9467	8.2451	4	4	6	9	14
355	8005	4.9975	3	4	5	6	14
356	31595	4.3123	2	3	4	5	7
357	6815	12.4031	5	7	10	15	23
358	23005	6.5868	3	4	5	7	11
359	28844	4.4908	3	4	4	5	6
360	9626	5.2339	2	3	4	5	9
361	440	5.7500	1	2	3	4	14
363	5695	4.3382	1	2	3	4	8
364	2842	4.1862	1	1	2	3	8
365	3169	10.7349	3	4	7	13	23
366	5027	10.0072	2	3	7	13	21
367	873	3.9210	1	1	2	3	8
368	1482	7.3657	2	4	6	9	14

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SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 12/91 GROUPER V9.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
369	2518	4.594	1	2	3	6	9
370	612	6.363	3	4	5	7	10
371	685	4.419	3	3	4	5	6
372	409	3.807	1	2	3	4	6
373	2513	2.522	1	2	2	3	3
374	67	4.000	2	2	2	3	5
375	7	14.714	1	2	2	7	14
376	146	2.740	1	2	2	7	14
377	27	5.074	1	1	2	3	5
378	138	3.652	2	3	3	7	10
379	310	2.971	2	3	3	4	6
380	66	2.818	1	1	2	3	6
381	222	2.432	1	1	2	3	5
382	58	1.448	1	1	1	4	4
383	842	4.426	1	2	3	2	2
384	98	2.724	1	1	3	5	9
385	5	5.600	1	1	2	3	6
386	1	149.000	149	149	149	149	15
387	1	6.000	6	6	6	6	149
388	9	8.556	1	5	6	6	6
389	28	6.536	1	2	9	9	11
390	1	2.000	1	2	4	11	14
391	1	14.079	2	2	2	2	2
392	2443	10.330	5	7	10	18	27
394	1980	6.446	1	2	6	12	22
395	70959	3.154	2	3	5	8	13
396	13	7.452	1	1	2	2	5
397	12488	8.302	2	3	5	9	15
398	14632	5.258	3	4	6	10	15
399	1681	13.330	1	2	4	7	10
400	8031	15.257	3	5	9	17	28
401	6988	5.211	3	6	11	19	32
402	2355	11.893	1	2	8	7	11
403	27920	5.685	2	5	8	15	25
404	5327	3.000	1	2	4	7	12
405	5	15.319	1	1	3	3	6
406	3783	6.492	4	7	11	19	31
407	977	8.535	2	3	5	8	11
408	5196	9.030	1	2	5	10	20
409	7548	3.621	2	4	5	11	20
410	125087	3.655	1	2	3	5	6
411	165	2.775	1	1	2	5	7
412	142	10.688	1	1	2	3	6
413	9559	6.013	2	4	8	13	22
414	1738	20.274	1	2	4	8	13
415	29908	10.338	5	9	15	25	40
416	135915	5.500	2	5	8	13	19
417	42	8.258	2	3	4	7	8
418	14224	7.428	3	4	6	10	15
419	16976	5.434	2	4	6	8	14
420	3737	5.583	2	3	4	7	10
421	12184		2	3	4	7	10

TABLE 7A - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY81 MEDPAR UPDATE 12/91 GROUPER V9.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
422	103	6.078	2	3	5	7	11
423	7136	10.896	3	5	8	13	22
424	2826	22.561	3	8	15	27	45
425	17758	6.483	2	3	3	8	13
426	5935	7.293	2	3	5	9	15
427	1979	7.866	1	3	5	9	16
428	1111	10.632	2	3	6	13	25
429	30483	12.055	3	4	7	13	25
430	55787	12.278	3	5	9	16	25
431	243	11.337	1	3	6	9	15
432	534	7.140	1	2	4	8	15
433	5788	4.536	1	1	3	5	11
434	18195	7.815	2	3	5	9	15
435	12116	6.330	2	3	5	7	13
436	2439	17.926	5	10	19	26	28
437	10653	16.676	6	10	15	23	28
438	944	8.394	1	4	8	12	22
439	4601	12.955	2	4	8	12	22
440	845	3.741	1	1	2	4	8
441	11317	9.878	1	3	6	12	21
442	5848	3.719	1	1	2	5	8
443	3891	7.287	2	3	5	8	13
444	2178	4.368	1	2	3	5	8
445	3122	3.495	1	1	2	4	7
446	1	1.000	1	1	1	1	1
447	29032	5.941	1	2	4	7	12
448	7484	3.318	1	1	2	4	7
449	17447	147.571	1	3	5	10	11
450	452	6.230	1	2	4	7	13
451	5851	3.570	1	2	4	7	13
452	4045	6.901	1	2	3	4	7
453	1100	3.295	1	2	4	8	14
454	173	9.035	1	2	4	8	14
455	122	9.115	1	2	4	10	21
456	1606	22.719	5	10	17	29	45
457	563	14.908	3	6	10	18	31
458	2377	9.178	2	4	7	12	19
459	5830	5.401	1	4	7	13	19
460	6330	17.789	5	8	15	23	33
461	9344	6.752	2	3	5	8	13
462	2953	4.149	1	2	3	5	8
463	533	3.079	1	1	3	5	8
464	3591	4.686	1	1	2	3	6
465	3376	6.102	1	1	2	3	6
466	72859	18.112	4	8	14	22	35
467	7574	14.050	7	9	14	16	23
468	178	29.315	1	8	23	42	62
469	8355	17.029	2	4	10	26	41
470	73010	13.666	2	6	11	18	27
471	10661	16.928	6	10	14	20	28
472	36161	10.349	1	3	7	13	21

TABLE 7A - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 12/91 GROUPER V9.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
478	102880	10.2410	2	4	7	13	21
479	17854	5.4843	1	2	5	7	10
480	75	40.4933	11	18	28	45	96
481	67	44.9552	23	31	39	50	72
482	6838	18.0759	6	9	13	21	34
483	32814	54.0528	17	27	43	67	99
484	289	22.9518	2	9	18	33	49
485	2511	16.4552	6	9	12	19	30
486	1730	16.9983	1	7	13	22	35
487	2846	11.1774	1	4	8	14	22
488	844	20.3140	2	9	15	25	39
489	4279	13.8995	3	5	9	16	28
490	1702	8.6710	1	3	5	10	19
491	6713	6.3799	3	3	5	8	11
492	1048	14.4637	3	4	6	24	34
=====							
10203666							

TABLE 7B - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 12/91 GROUPER V10.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
001	28268	15.7441	4	7	11	19	31
002	5716	14.9003	4	7	11	19	30
003	3	2.0000	1	1	1	4	4
004	5127	13.0521	3	5	9	16	27
005	52807	6.7496	2	3	5	8	13
006	854	3.3162	1	1	2	3	7
007	5742	21.2179	2	6	11	22	45
008	2699	4.5954	1	1	3	6	10
009	1678	10.5864	2	4	7	12	21
010	19835	10.8720	2	4	7	14	22
011	3528	6.4212	1	2	4	8	13
012	21359	10.4106	2	4	7	12	19
013	5571	8.5144	3	4	7	10	15
014	337593	9.9669	3	4	7	12	19
015	133891	5.4328	2	3	4	6	10
016	11011	9.3524	3	4	7	11	18
017	2862	5.7667	2	3	5	7	10
018	13605	7.9338	2	4	6	9	15
019	6848	5.4936	1	2	4	7	11
020	7404	12.4114	2	5	9	15	25
021	1006	9.6928	3	4	7	12	19
022	9891	5.5158	2	3	4	7	10
023	3067	6.2097	1	2	4	7	12
024	53265	7.3423	2	3	5	9	14
025	22480	4.4321	1	2	3	5	8
026	55	5.6727	1	2	3	7	14
027	2678	7.9623	1	2	4	10	18
028	7878	9.4439	2	3	6	11	19
029	3540	4.8621	1	2	3	6	10
030	2	1.0000	1	1	1	1	1
031	3572	6.6249	2	2	4	7	13
032	2583	3.6806	1	2	3	4	7
034	13461	8.8028	2	3	6	10	17
035	3768	5.2806	1	2	4	8	10
036	20229	2.3422	1	1	2	3	4
037	2665	4.4649	1	1	2	3	10
038	770	2.8208	1	1	2	3	5
039	9581	1.9363	1	1	2	2	3
040	3321	3.4192	1	1	2	4	7
042	20297	2.5528	1	1	2	4	5
043	201	5.6866	1	1	2	6	11
044	1962	6.2819	2	4	5	7	11
045	2588	4.4532	1	2	4	6	8
046	2878	6.2827	1	2	4	8	12
047	1859	4.4330	1	2	3	5	8
048	2	7.0000	5	5	9	9	16
049	2667	7.6923	2	3	5	9	16
050	4902	2.6391	1	1	2	3	4
051	524	2.8645	1	1	2	3	6
052	171	3.1482	1	1	2	3	6
053	6387	3.4481	1	1	2	3	8

TABLE 78 - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 12/91 GROUPEE V10.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
055	3589	2.7317	1	1	1	2	6
056	1090	2.7009	1	1	2	3	6
057	656	5.3750	1	2	3	6	11
058	1	1.0000	1	1	1	1	1
059	183	2.1858	1	1	1	2	4
061	381	5.0919	1	1	2	6	12
063	4780	5.7492	1	2	4	7	12
064	4332	8.7652	1	2	5	11	20
065	32014	4.1498	1	2	3	5	8
066	7733	4.3419	1	2	3	5	8
067	425	5.1671	2	3	4	6	9
068	11536	5.9536	2	3	5	7	11
069	3729	4.3124	2	3	4	5	8
070	17	4.5294	1	2	3	5	9
071	132	5.0682	2	3	4	6	10
072	673	5.7281	1	2	3	5	9
073	6546	6.0053	1	2	3	5	10
074	2	11.0000	9	9	13	13	13
075	31763	13.7042	6	8	10	13	25
076	75079	14.3224	4	7	11	18	27
078	6545	7.5325	1	3	6	10	15
078	26477	10.0135	4	7	9	12	16
079	132677	11.6036	4	6	9	14	21
080	8940	7.7613	3	6	9	14	14
081	1	7.0000	7	7	7	7	7
082	58814	9.0936	2	4	7	12	19
083	7021	8.1493	2	4	6	10	15
084	1793	4.4577	1	2	3	6	8
085	16889	8.8759	2	4	7	11	17
086	1697	5.2787	1	2	4	7	10
087	61021	8.0394	2	4	6	10	15
088	161966	7.3437	3	4	6	9	13
089	368544	8.6408	3	5	7	10	15
090	45578	6.1821	3	4	7	7	10
091	44	6.1136	2	3	5	7	11
092	8321	8.5321	3	4	7	10	16
093	1327	5.8425	2	4	5	7	10
094	8350	9.3702	3	4	7	11	18
095	1287	5.3963	3	3	4	7	10
096	176236	7.0607	3	4	6	8	12
097	32075	5.1441	2	3	5	8	9
098	17	6.2941	2	3	5	6	10
098	30114	5.1423	2	2	4	6	10
100	11199	3.1203	1	2	4	4	6
101	18008	6.6578	2	3	5	8	13
102	3535	4.2795	2	2	4	4	8
103	238	32.1723	10	14	23	38	62
104	17372	20.2585	9	12	17	25	35
105	15979	14.4294	7	9	11	16	25
106	74580	15.2254	8	10	13	17	24
107	52388	11.7606	7	8	10	13	18

TABLE 78 - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 12/91 GROUPER V10.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
108	8815	15.1239	7	9	12	18	27
110	50710	13.4182	3	8	11	16	25
111	6320	8.4106	3	6	8	10	13
112	128626	6.0884	2	3	5	8	12
113	38406	18.7793	6	8	14	22	37
114	8076	12.4459	3	5	9	15	24
115	8203	13.8518	5	8	11	17	24
116	64667	7.2072	2	3	5	9	14
117	3247	5.5079	1	2	3	7	12
118	8174	3.9172	1	1	2	4	9
119	3204	6.2644	1	2	3	7	15
120	33573	12.3955	2	3	8	16	27
121	143327	9.6028	4	6	8	11	18
122	99268	6.8777	2	4	7	11	11
123	55036	5.2981	1	1	3	7	13
124	123627	5.7604	1	1	2	7	11
125	88564	3.1515	1	1	2	4	7
126	4203	20.4149	5	10	16	29	41
127	602239	7.7143	2	4	6	9	14
128	23149	8.4068	4	5	7	10	13
129	6227	4.7468	1	1	1	6	12
130	70683	8.0792	2	4	7	10	14
131	26293	5.9626	1	1	1	6	10
132	12691	5.5565	1	1	3	7	11
133	4152	3.9188	1	2	2	5	7
134	28006	4.9812	2	2	3	6	9
135	6404	6.6284	2	2	4	8	13
136	1428	4.3690	1	1	3	5	7
138	185487	5.8414	2	2	3	7	11
139	71704	3.6838	1	1	2	4	7
140	341502	4.4890	2	2	3	5	8
141	76370	5.6784	2	2	4	7	10
142	36764	3.9269	1	1	3	5	7
143	115719	3.3748	1	1	2	4	6
144	55652	7.0829	2	2	3	5	8
145	8435	4.1801	1	1	2	4	6
146	7565	13.7870	7	8	11	15	22
147	1620	8.9848	5	7	9	11	15
148	141393	15.8461	7	9	12	18	28
149	18120	8.0679	6	7	8	10	13
150	21587	13.8921	5	6	11	17	24
151	4781	7.7833	5	6	7	10	13
152	4551	10.6339	5	7	9	12	18
153	2048	7.0459	4	5	7	8	10
154	37035	17.3283	7	8	14	22	34
155	4178	8.6084	4	5	7	10	14
156	13128	6.5957	2	3	5	8	13
157	9959	3.0688	1	1	2	4	6
158	16227	6.3665	2	2	3	5	8
159	12821	3.3392	1	1	2	4	6
160	23791	4.6269	1	1	2	4	6

TABLE 7B - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 12/91 GROUPER V10.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
162	21101	2.2025	1	1	2	3	4
163	10	2.4000	1	2	2	3	4
164	4578	11.3872	5	7	9	13	19
165	1794	7.0284	4	5	7	9	11
166	2832	7.1538	3	4	6	9	13
167	2170	4.1253	2	3	4	5	7
168	1788	5.7943	1	2	3	4	7
169	1366	2.9129	1	1	2	3	6
170	12713	15.6310	3	7	11	19	31
171	1463	6.9412	1	3	6	9	13
172	31140	10.3381	2	4	7	13	21
173	3337	5.2517	1	2	4	7	11
174	165016	6.9276	2	4	5	8	13
175	22542	4.3682	2	3	4	5	7
176	12892	7.7026	2	4	6	9	14
177	14855	6.2788	2	3	5	8	11
178	6418	4.4483	2	3	5	8	11
179	8630	9.5102	3	4	7	11	18
180	69302	7.6203	2	4	6	9	14
181	22049	4.5862	2	3	4	6	8
182	256259	6.2255	2	3	5	8	11
183	78176	4.5400	1	2	4	5	8
184	50	3.6000	1	2	3	4	6
185	3831	6.3156	1	3	5	8	13
186	1	4.0000	4	4	5	8	14
187	997	3.9529	1	1	2	3	5
188	49808	7.3748	2	3	4	5	8
189	9043	3.8545	1	3	5	9	14
190	94	5.2447	1	1	3	5	10
191	10080	19.7739	6	10	15	24	39
192	985	9.6020	3	6	8	12	18
193	12295	16.5587	7	9	14	20	29
194	1416	9.7041	3	6	9	12	17
195	17110	12.2889	6	7	10	14	20
196	1856	8.2193	4	5	7	10	13
197	76376	8.4937	2	4	7	11	16
198	48653	3.6350	1	1	3	5	7
199	2829	14.2616	4	7	11	18	27
200	1923	13.5190	2	5	10	17	28
201	2997	14.3784	3	6	10	18	30
202	17745	9.6320	2	4	7	12	19
203	29497	9.7206	2	4	7	12	20
204	39199	8.0600	3	4	6	9	15
205	20814	9.1418	2	4	7	11	18
206	2413	5.0220	1	2	4	7	10
207	37528	7.0338	2	3	5	9	13
208	14008	4.0415	1	2	3	5	7
209	267627	10.5536	6	7	9	12	16
210	116591	12.9940	6	8	9	12	21
211	28911	9.4425	5	6	8	11	14
212	18	6.1111	2	2	3	7	9

TABLE 7B - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 12/91 GROUPER V10.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
213	5738	12.8313	3	6	9	18	25
214	41313	10.2321	4	5	8	12	19
215	37991	6.0864	3	4	5	7	10
216	7018	14.4741	3	6	11	18	29
217	16628	21.0197	4	7	14	27	45
218	18336	9.0046	3	4	7	11	17
219	17781	5.1599	2	3	4	6	9
220	4	2.2500	1	1	2	3	3
221	4858	10.7091	2	4	8	13	21
222	5229	5.2878	1	1	2	3	10
223	15713	4.0320	1	2	3	4	7
224	8728	2.8997	1	2	3	4	5
225	8983	5.2825	1	2	3	4	5
226	5452	8.9762	2	3	6	11	20
227	8465	3.8863	1	2	3	4	7
228	4327	3.7123	1	1	2	3	5
229	2505	2.6591	1	1	2	3	4
230	3230	6.4412	1	2	4	7	13
231	10173	6.5634	1	2	4	7	13
232	793	6.5523	1	2	4	7	13
233	5188	11.6795	3	5	9	15	23
234	3023	5.4016	1	2	3	4	5
235	6239	11.1856	1	2	4	7	13
236	38320	8.8097	2	3	6	11	17
237	1681	5.8257	1	2	3	4	5
238	6361	13.9027	2	4	7	12	19
239	59318	10.0120	3	5	10	17	28
240	10920	9.3950	3	5	10	17	28
241	3950	5.5463	2	3	5	7	11
242	2488	10.5086	3	5	9	13	18
243	103841	6.8288	2	3	5	7	11
244	11051	7.2525	2	3	5	7	11
245	5661	5.3374	1	2	3	4	5
246	1726	5.4177	1	2	3	4	5
247	9689	5.0789	1	2	3	4	5
248	6248	6.1908	1	2	3	4	5
249	8359	6.3973	1	2	3	4	5
250	3353	6.7781	1	2	3	4	5
251	3237	3.6256	1	1	2	3	4
252	18958	8.1943	2	3	6	11	18
253	12121	4.7225	1	2	3	4	5
254	2	2.5000	1	1	2	3	4
255	9233	5.4512	1	2	3	4	5
256	28218	5.1278	1	2	3	4	5
257	26390	3.6482	1	2	3	4	5
258	4004	5.9298	1	2	3	4	5
259	4979	2.5700	1	1	2	3	4
260	2841	2.8259	1	1	2	3	4
261	1302	3.5661	1	1	2	3	4
262	28743	20.2119	5	8	14	24	40
263	4186	11.3512	3	5	8	14	23

TABLE 78 - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 12/91 GROUPER V10.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
265	4915	9.6867	2	3	6	11	21
266	4167	4.3252	1	2	3	5	9
267	368	4.9837	1	1	3	5	11
268	1410	5.1723	1	1	2	5	9
269	10906	12.2327	2	4	9	15	25
270	5130	4.0310	1	2	3	5	9
271	19868	11.4729	3	5	8	13	21
272	6799	9.3836	3	5	7	11	18
273	2194	6.8090	2	3	5	8	14
274	3139	10.9341	2	4	7	12	21
275	401	5.7232	1	2	3	6	9
276	867	5.7151	1	2	4	7	11
277	70557	8.4681	3	5	7	10	15
278	25890	6.1614	3	4	5	7	11
279	6	7.0000	2	3	5	11	11
280	12914	6.7166	2	3	5	8	13
281	7188	4.1994	2	2	3	5	8
282	1	2.0000	1	2	2	2	2
283	5814	7.3003	2	3	5	8	14
284	2389	5.0682	1	2	4	6	9
285	4549	20.6736	5	9	15	25	40
286	1721	11.2702	5	6	8	13	22
287	6493	18.7138	4	7	12	21	38
288	507	10.4694	3	4	7	10	21
289	3955	5.6718	2	2	3	5	8
290	9577	3.4522	1	2	2	4	6
291	143	2.1049	1	2	2	2	4
292	5044	17.6921	4	7	13	21	35
293	505	7.4950	1	3	6	10	15
294	89720	7.2549	3	4	6	8	13
295	3252	5.8483	2	3	4	7	11
296	210976	8.3160	2	4	6	10	16
297	44441	5.1711	2	3	4	6	9
298	65	4.6308	1	2	2	5	8
299	877	6.5530	1	2	5	8	13
300	11785	9.3115	3	4	7	11	18
301	2074	5.2160	1	2	4	7	10
302	6513	15.9483	7	9	13	19	28
303	17481	13.2953	6	8	10	15	23
304	13876	13.3942	6	6	10	16	26
305	3517	6.4578	2	3	6	8	12
306	12341	8.8255	3	4	6	11	17
307	4325	4.5686	2	3	4	5	8
308	10288	9.0454	2	3	6	11	19
309	4383	3.9877	1	2	3	5	8
310	35212	5.6127	1	2	3	7	11
311	19528	2.6869	1	1	2	3	5
312	3102	5.5239	1	2	4	7	11
313	1818	2.7629	1	1	2	3	5
314	1	8.0000	8	8	8	8	8
315	26943	12.2125	1	3	7	15	27

TABLE 7B - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 12/91 GROUPER V10.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
316	49066	9.1396	2	4	7	12	18
317	707	4.1782	1	2	3	4	8
318	6861	8.9922	2	3	6	11	19
319	884	3.7886	1	1	2	4	8
320	182684	8.3690	3	4	6	10	15
321	29134	5.8757	2	3	5	7	10
322	50	5.8400	2	3	5	7	10
323	20541	4.2749	1	2	3	5	9
324	13478	2.5819	1	1	2	3	5
325	9618	5.7650	2	3	4	7	11
326	3609	3.5658	1	2	3	4	7
327	9	7.0000	1	2	3	4	10
328	1257	4.9578	1	2	3	4	9
329	341	2.9003	1	1	2	3	5
331	29323	7.4644	2	3	5	9	15
332	5847	4.4404	1	2	3	5	9
333	311	7.5948	2	3	5	10	18
334	22366	9.1218	5	6	8	10	14
335	10820	7.2799	5	6	7	8	10
336	105208	5.7983	3	3	4	7	10
337	88453	3.8239	2	3	3	4	8
338	7448	5.2254	1	1	2	4	6
339	3230	4.6888	1	1	2	5	11
340	2	5.0000	3	3	7	7	8
341	12839	4.3806	1	2	3	5	8
342	410	3.8610	1	1	2	4	9
343	2	2.0000	1	1	3	4	3
344	4825	5.3988	1	2	4	6	10
345	2512	4.8949	1	2	3	5	10
346	7797	8.5775	2	3	6	10	17
347	953	4.3894	1	1	3	7	9
348	4269	5.7128	1	2	4	7	11
349	1634	3.1157	1	1	2	4	6
350	7998	5.8718	2	3	5	7	10
351	1	6.0000	6	6	6	6	6
352	770	4.8065	1	2	3	6	10
353	2321	11.4942	1	2	3	6	21
354	9467	8.2451	5	5	9	14	21
355	6005	4.9975	4	5	6	9	14
356	31595	4.3123	3	4	5	6	7
357	6815	12.4031	5	7	10	15	23
358	23005	6.5669	3	4	5	7	11
359	26844	4.4908	3	4	4	5	6
360	9626	5.2339	2	3	4	5	9
361	440	5.7500	1	2	4	6	14
363	5695	4.3392	1	2	3	4	8
364	2642	4.1882	1	1	2	3	5
365	3169	10.7349	3	4	7	13	23
366	5027	10.0072	2	3	7	13	21
367	873	3.9210	1	1	3	4	8
368	1482	7.3657	2	4	6	9	14

TABLE 7B - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 12/91 GROUPEE V10.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
369	2518	4.584	1	2	3	6	9
370	612	6.363	3	4	5	7	10
371	685	4.419	1	2	3	5	6
372	408	3.807	1	2	3	4	5
373	2513	2.522	1	2	2	3	3
374	67	4.000	2	2	2	3	5
375	7	14.714	1	2	2	3	14
376	146	2.740	1	1	2	2	5
377	27	5.074	1	2	2	3	14
378	138	3.652	2	3	3	4	5
379	310	2.971	1	1	2	3	10
380	66	2.818	1	1	2	3	6
381	222	2.432	1	1	1	2	6
382	58	1.448	1	1	1	2	5
383	842	4.426	1	2	2	3	4
384	98	2.724	1	1	1	2	2
385	5	5.600	1	1	1	2	3
386	149,000	149,000	149	149	149	149	15
387	1	6.000	6	6	6	8	149
388	1	8.556	1	5	9	11	6
389	28	6.536	1	2	4	9	11
390	1	2.000	2	2	2	2	14
391	1	14.078	5	7	10	12	2
392	2443	10.330	1	2	3	5	27
394	1980	6.446	2	3	5	8	22
395	70959	3.154	1	1	2	2	13
396	13	7.452	2	3	5	8	5
397	12888	8.302	1	2	3	5	15
398	14632	5.258	3	4	5	7	15
399	1581	13.330	1	2	3	4	10
400	8031	15.257	3	5	8	10	17
401	6888	5.211	2	2	3	4	28
402	2355	11.893	1	2	3	4	32
403	27920	5.685	1	2	3	4	11
404	5327	3.000	1	1	2	3	25
405	5	15.319	1	1	2	3	12
406	3783	6.432	4	7	11	19	6
407	877	8.535	2	3	5	8	31
408	5196	9.030	2	3	5	8	11
409	7546	3.621	2	3	5	8	20
410	125087	3.655	1	2	3	4	20
411	185	2.775	1	1	2	3	6
412	142	10.688	1	2	3	4	7
413	9559	6.013	2	3	5	8	6
414	1738	20.274	1	2	3	4	22
415	29908	10.339	2	3	5	8	13
416	135915	5.500	2	3	5	8	40
417	42	8.258	2	3	5	8	19
418	14224	7.428	2	3	5	8	8
419	16976	5.434	2	3	5	8	15
420	3737	5.583	2	3	5	8	14
421	12184		2	3	5	8	10

TABLE 7B - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 12/91 GROUPER V10.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
422	103	6.078	2	3	5	7	11
423	7136	10.896	3	5	8	13	22
424	2826	22.561	3	8	15	27	45
425	17758	6.483	2	3	4	8	13
426	5935	7.293	2	3	5	9	15
427	1979	7.866	1	3	5	9	16
428	1111	10.632	2	3	6	13	25
429	30483	12.055	3	4	7	13	23
430	55787	12.278	3	5	9	16	25
431	243	11.337	1	3	6	9	15
432	534	7.140	1	2	4	8	15
433	5778	4.511	1	1	3	5	11
434	17964	7.667	2	3	5	7	13
435	12086	6.317	2	3	5	7	13
436	2428	17.904	5	10	19	26	28
437	10592	16.628	6	10	15	23	28
438	944	9.394	1	3	6	12	22
440	4601	12.955	2	4	8	16	28
441	845	3.741	1	1	2	4	8
442	11317	9.876	1	3	6	12	21
443	5848	3.719	1	1	2	5	8
444	3891	7.287	2	3	5	8	13
445	2178	4.368	1	2	3	5	8
447	3122	3.495	1	1	2	4	7
448	1	1.000	1	1	1	1	1
449	29032	5.841	1	2	4	7	12
450	7484	3.318	1	1	2	4	7
451	7	147.571	1	3	5	10	13
452	17447	6.230	1	2	4	7	13
453	5851	3.570	1	2	4	7	14
454	4045	6.901	1	2	4	8	14
455	1100	3.285	1	1	2	4	8
456	173	9.035	1	2	4	7	14
457	122	9.115	1	2	4	7	14
458	1806	22.719	5	10	17	29	45
459	583	14.909	3	6	10	18	31
460	2377	9.176	2	4	7	12	19
461	5830	5.401	1	1	2	5	13
462	6530	17.789	5	8	15	23	33
463	9344	6.782	2	3	5	8	13
464	2953	4.149	1	2	3	5	8
465	533	3.079	1	1	2	3	8
466	3591	4.688	1	1	2	3	8
467	3376	6.102	1	1	2	3	9
468	73065	18.124	4	8	14	22	35
471	7574	14.050	4	8	14	22	35
472	178	29.315	7	9	23	42	62
473	8355	17.029	1	4	10	28	41
475	73010	13.686	2	6	14	20	27
476	10713	16.946	6	10	14	20	29
477	36245	10.355	1	3	7	13	21

TABLE 7B - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 12/91 GROUPEL V10.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
478	102877	10.2409	2	4	7	13	21
479	17854	5.4843	1	2	5	7	10
480	75	40.4933	11	16	28	45	86
481	67	44.8552	23	31	39	50	72
482	6838	18.0759	6	9	13	21	34
483	32814	54.0528	17	27	43	67	88
484	289	22.9516	2	9	18	33	49
485	2511	18.4552	6	9	12	19	30
486	1730	16.6983	1	7	13	22	35
487	2846	11.1774	2	4	8	14	22
488	844	20.3140	5	9	15	25	39
489	4279	13.8995	3	5	9	16	28
490	1702	8.6710	1	3	5	10	18
491	6713	6.3789	3	4	5	8	11
492	1048	14.4637	3	4	6	24	34
	=====						
	10203866						

BILLING CODE 4120-01-C

TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED) APRIL 1992

State	Urban	Rural
Alabama	0.503647	0.530099
Alaska	0.769846	0.882596
Arizona	0.579847	0.620998
Arkansas	0.583693	0.570674
California	0.511337	0.565421
Colorado	0.586320	0.624826
Connecticut	0.646590	0.688155
Delaware	0.616202	0.640679
District of Columbia	0.572248	
Florida	0.497297	0.505095
Georgia	0.592786	0.578752
Hawaii	0.629273	0.753597
Idaho	0.667878	0.671385
Illinois	0.567290	0.614793
Indiana	0.668811	0.679592
Iowa	0.680816	0.741266
Kansas	0.634933	0.709132
Kentucky	0.586710	0.583233
Louisiana	0.558362	0.598960
Maine	0.670862	0.626500
Maryland	0.768898	0.806322
Massachusetts	0.711945	0.858405
Michigan	0.580700	0.659005
Minnesota	0.662974	0.722085
Mississippi	0.596325	0.583217
Missouri	0.541151	0.585243
Montana	0.675568	0.700140
Nebraska	0.654524	0.722772
Nevada	0.509109	0.677714
New Hampshire	0.679143	0.686632
New Jersey	0.796232	
New Mexico	0.547462	0.582679
New York	0.672745	0.738413
North Carolina	0.627158	0.581949
North Dakota	0.684004	0.712080
Ohio	0.634724	0.662139
Oklahoma	0.574143	0.606318
Oregon	0.634317	0.681224
Pennsylvania	0.531257	0.601704

TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED) APRIL 1992—Continued

State	Urban	Rural
Puerto Rico	0.532837	0.633205
Rhode Island	0.765000	
South Carolina	0.562383	0.544672
South Dakota	0.664001	0.686325
Tennessee	0.575922	0.579831
Texas	0.574424	0.660252
Utah	0.625688	0.648080
Vermont	0.668931	0.666817
Virginia	0.585301	0.598326
Washington	0.710180	0.739728
West Virginia	0.580977	0.567044
Wisconsin	0.724494	0.736675
Wyoming	0.746141	0.774423

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED) APRIL 1992

State	Ratio
Alabama	0.062910
Alaska	0.105552
Arizona	0.078547
Arkansas	0.067798
California	0.051154
Colorado	0.056786
Connecticut	0.040184
Delaware	0.064672
District of Columbia	0.045503
Florida	0.068092
Georgia	0.060021
Hawaii	0.060616
Idaho	0.068879
Illinois	0.052549
Indiana	0.067411
Iowa	0.063290

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED) APRIL 1992—Continued

State	Ratio
Kansas	0.062413
Kentucky	0.066616
Louisiana	0.081314
Maine	0.049786
Maryland	0.057705
Massachusetts	0.056731
Michigan	0.058711
Minnesota	0.060940
Mississippi	0.060694
Missouri	0.060135
Montana	0.071759
Nebraska	0.061103
Nevada	0.055191
New Hampshire	0.063597
New Jersey	0.079028
New Mexico	0.060087
New York	0.066052
North Carolina	0.055494
North Dakota	0.073101
Ohio	0.064051
Oklahoma	0.068489
Oregon	0.052530
Pennsylvania	0.053267
Puerto Rico	0.082128
Rhode Island	0.042000
South Carolina	0.067906
South Dakota	0.071816
Tennessee	0.068952
Texas	0.070990
Utah	0.064948
Vermont	0.060000
Virginia	0.069063
Washington	0.083107
West Virginia	0.064799
Wisconsin	0.072273
Wyoming	0.082848

BILLING CODE 4120-01-M

Table 9 -- 1991 Transfer Adjusted Case Mix Index and Transfer
Adjustment to Discharges for Capital Hospital-Specific
Rate Redeterminations

Page 1 of 21

PROVIDER NUMBER	COST REPORTING PERIOD BEGIN - END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES	PROVIDER NUMBER	COST REPORTING PERIOD BEGIN - END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES
010006	07/01/90 - 06/30/91	1.3318	0.9949	020010	07/01/90 - 06/30/91	0.9867	0.9817
010011	07/01/90 - 06/30/91	1.3454	0.9988	020011	07/01/90 - 06/30/91	0.9882	0.9725
010012	07/01/90 - 06/30/91	1.2362	0.9661	020014	07/01/90 - 06/30/91	0.9086	1.0000
010015	04/01/90 - 03/31/91	1.0662	0.9175	020024	07/01/90 - 06/30/91	1.0355	0.9484
010018	07/01/90 - 06/30/91	0.8805	0.9916	030003	07/01/90 - 06/30/91	1.3396	0.9908
010020	07/01/90 - 06/30/91	1.0207	0.9759	030006	07/01/90 - 06/30/91	1.5371	0.9983
010022	07/01/90 - 06/30/91	0.9361	0.9705	030007	07/01/90 - 06/30/91	1.2967	0.9736
010023	07/01/90 - 06/30/91	1.2745	0.9881	030009	07/01/90 - 06/30/91	1.2077	0.9881
010024	07/01/90 - 06/30/91	1.2319	0.9898	030010	07/01/90 - 06/30/91	1.4283	0.9981
010025	07/01/90 - 06/30/91	1.2077	0.9725	030011	07/01/90 - 06/30/91	1.3591	0.9948
010031	07/01/90 - 06/30/91	1.3116	0.9928	030016	07/01/90 - 06/30/91	1.2920	0.9829
010034	07/01/90 - 06/30/91	1.0534	0.9659	030017	07/01/90 - 06/30/91	1.3601	0.9968
010036	04/01/90 - 03/31/91	1.1152	0.9710	030019	07/01/90 - 06/30/91	1.2897	0.9928
010038	07/01/90 - 06/30/91	1.1979	0.9851	030022	07/01/90 - 06/30/91	1.3555	0.9927
010039	07/01/90 - 06/30/91	1.5773	0.9972	030024	07/01/90 - 06/30/91	1.6087	0.9985
010050	07/01/90 - 06/30/91	0.9590	0.9530	030027	07/01/90 - 06/30/91	1.0636	0.9941
010053	07/01/90 - 06/30/91	1.0024	0.9443	030033	07/01/90 - 06/30/91	1.3781	0.9736
010054	07/01/90 - 06/30/91	1.1958	0.9795	030034	04/01/90 - 03/31/91	1.0818	0.9743
010055	07/01/90 - 06/30/91	1.3327	0.9984	030037	07/01/90 - 06/30/91	1.8599	0.9982
010056	07/01/90 - 06/30/91	1.2769	0.9925	030040	07/01/90 - 06/30/91	0.9830	0.9474
010058	07/01/90 - 06/30/91	0.9387	0.9500	030043	07/01/90 - 06/30/91	1.1538	0.9556
010064	07/01/90 - 06/30/91	1.6140	0.9983	030049	07/01/90 - 06/30/91	0.9213	0.9499
010066	07/01/90 - 06/30/91	0.9333	0.9334	030051	07/01/90 - 06/30/91	1.0406	0.9833
010068	07/01/90 - 06/30/91	1.2011	0.9868	030054	07/01/90 - 06/30/91	0.8915	0.9644
010072	07/01/90 - 06/30/91	1.1296	0.9560	030055	07/01/90 - 06/30/91	1.2142	0.9754
010078	07/01/90 - 06/30/91	1.1567	0.9896	030059	07/01/90 - 06/30/91	1.584	0.9819
010080	04/01/90 - 03/31/91	0.9553	0.9704	030064	07/01/90 - 06/30/91	1.5351	0.9934
010085	07/01/90 - 06/30/91	1.2940	0.9755	030080	04/01/90 - 03/31/91	1.4964	0.9984
010086	07/01/90 - 06/30/91	0.9715	0.9642	030091	07/01/90 - 06/30/91	0.7698	0.9730
010089	07/01/90 - 06/30/91	1.0720	0.9890	040001	04/01/90 - 03/31/91	1.0270	0.9645
010090	07/01/90 - 06/30/91	1.4694	0.9985	040002	07/01/90 - 06/30/91	1.1748	0.9751
010091	07/01/90 - 06/30/91	1.0299	0.9703	040003	07/01/90 - 06/30/91	1.0253	0.9708
010098	07/01/90 - 06/30/91	1.0314	0.9743	040008	07/01/90 - 06/30/91	1.0125	0.9738
010101	07/01/90 - 06/30/91	1.0561	0.9752	040011	07/01/90 - 06/30/91	0.9218	0.9666
010103	07/01/90 - 06/30/91	1.5225	0.9988	040015	07/01/90 - 06/30/91	1.0427	0.9094
010104	07/01/90 - 06/30/91	1.5706	0.9978	040016	07/01/90 - 06/30/91	1.4587	0.9968
010113	04/01/90 - 03/31/91	1.5668	0.9988	040017	04/01/90 - 03/31/91	1.2153	0.9777
010114	07/01/90 - 06/30/91	1.1897	0.9854	040019	07/01/90 - 06/30/91	1.1983	0.9460
010118	07/01/90 - 06/30/91	1.1508	0.9820	040022	07/01/90 - 06/30/91	1.6607	0.9974
010121	07/01/90 - 06/30/91	1.0974	0.9834	040025	07/01/90 - 06/30/91	1.0037	0.9661
010128	07/01/90 - 06/30/91	0.8733	0.9528	040026	07/01/90 - 06/30/91	1.4063	0.9961
010131	07/01/90 - 06/30/91	1.2598	0.9885	040030	07/01/90 - 06/30/91	0.9387	0.9412
010134	04/01/90 - 03/31/91	0.8210	0.9206	040032	07/01/90 - 06/30/91	0.9155	0.9781
010136	05/01/90 - 04/30/91	0.9766	0.9505	040035	07/01/90 - 06/30/91	0.9287	0.9822
010138	07/01/90 - 06/30/91	0.9094	0.9103	040039	07/01/90 - 06/30/91	1.0442	0.9772
010145	02/01/90 - 01/31/91	1.2126	0.9963	040040	07/01/90 - 06/30/91	0.9753	0.9722
010148	07/01/90 - 06/30/91	0.9575	0.9381	040048	07/01/90 - 06/30/91	1.2030	0.9822
010150	04/01/90 - 03/31/91	1.0014	0.9969	040051	04/01/90 - 03/31/91	0.9766	0.9387
020002	07/01/90 - 06/30/91	1.1907	0.9743	040053	07/01/90 - 06/30/91	1.0508	0.9096
020004	07/01/90 - 06/30/91	1.1270	0.9683	040054	07/01/90 - 06/30/91	0.9589	0.9775
020007	07/01/90 - 06/30/91	1.1966	0.9370	040055	07/01/90 - 06/30/91	1.3329	0.9984
020008	07/01/90 - 06/30/91	0.9888	0.9822	040058	06/05/90 - 06/30/91	0.8994	0.9783
020009	07/01/90 - 06/30/91	0.8102	1.0000	040060	02/01/90 - 01/31/91	0.9341	0.9297

Table 9 -- 1991 Transfer Adjusted Case Mix Index and Transfer
Adjustment to Discharges for Capital Hospital-Specific
Rate Redeterminations

Page 2 of 21

PROVIDER NUMBER	COST REPORTING PERIOD BEGIN - END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES	PROVIDER NUMBER	COST REPORTING PERIOD BEGIN - END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES
040062	07/01/90 - 06/30/91	1.3005	0.9944	050079	07/01/90 - 06/30/91	1.4862	0.9984
040063	07/01/90 - 06/30/91	1.4273	0.9972	050082	07/01/90 - 06/30/91	1.4779	0.9969
040064	07/01/90 - 06/30/91	0.9041	0.9210	050088	07/01/90 - 06/30/91	1.1429	0.9920
040071	07/01/90 - 06/30/91	1.3970	0.9963	050089	07/01/90 - 06/30/91	1.3373	0.9859
040074	07/01/90 - 06/30/91	1.1602	0.9876	050090	07/01/90 - 06/30/91	1.2284	0.9873
040076	07/01/90 - 06/30/91	0.9848	0.9598	050092	07/01/90 - 06/30/91	0.9762	0.9720
040077	07/01/90 - 06/30/91	0.9402	0.9586	050093	06/01/90 - 05/31/91	1.5178	0.9989
040080	07/01/90 - 06/30/91	1.0560	0.9402	050095	07/01/90 - 06/30/91	1.8435	0.8663
040082	07/01/90 - 06/30/91	1.2148	0.9701	050104	07/01/90 - 06/30/91	1.3575	0.9968
040084	07/01/90 - 06/30/91	1.1084	0.9771	050110	07/01/90 - 06/30/91	1.1105	0.9714
040088	07/01/90 - 06/30/91	1.1955	0.9869	050113	07/01/90 - 06/30/91	1.2424	0.9848
040090	07/01/90 - 06/30/91	0.9599	0.9130	050114	05/01/90 - 04/30/91	1.5048	0.9818
040091	07/01/90 - 06/30/91	1.1241	0.9675	050115	07/01/90 - 06/30/91	1.4688	0.9950
040093	07/01/90 - 06/30/91	0.9799	0.9613	050116	07/01/90 - 06/30/91	1.4136	0.9944
040095	07/01/90 - 06/30/91	0.8631	0.9079	050118	06/01/90 - 05/31/91	1.1620	0.9835
040109	07/01/90 - 06/30/91	1.1434	0.9832	050124	07/01/90 - 06/30/91	1.2072	0.9888
040116	03/01/90 - 02/28/91	1.2866	0.9990	050128	07/01/90 - 06/30/91	1.4877	0.9980
040124	07/01/90 - 06/30/91	1.1476	0.9645	050129	07/01/90 - 06/30/91	1.5105	0.9956
040126	07/01/90 - 06/30/91	0.9731	0.9588	050133	07/01/90 - 06/30/91	1.1788	0.9732
050006	07/01/90 - 06/30/91	1.3166	0.9912	050136	07/01/90 - 06/30/91	1.3058	0.9803
050009	07/01/90 - 06/30/91	1.6158	0.9944	050143	04/01/90 - 03/31/91	1.4183	0.9963
050014	07/01/90 - 06/30/91	1.0829	0.9688	050147	06/01/90 - 05/31/91	0.7395	0.9830
050016	07/01/90 - 06/30/91	1.4391	0.9748	050148	07/01/90 - 06/30/91	1.1109	0.9612
050017	01/01/90 - 01/23/91	1.1070	0.9845	050152	07/01/90 - 06/30/91	1.4031	0.9938
050019	04/01/90 - 03/31/91	1.9631	0.9978	050153	07/01/90 - 06/30/91	1.8231	0.9978
050025	07/01/90 - 06/30/91	0.8275	0.9656	050158	04/01/90 - 03/31/91	1.6706	0.9962
050026	07/01/90 - 06/30/91	1.6859	0.9938	050159	07/01/90 - 06/30/91	1.3933	0.9913
050028	07/01/90 - 06/30/91	1.4891	0.9936	050161	05/01/90 - 04/30/91	1.8192	0.9912
050029	07/01/90 - 06/30/91	1.2805	0.9877	050166	07/01/90 - 06/30/91	1.0269	0.9715
050033	07/01/90 - 06/30/91	1.3733	0.9852	050167	07/01/90 - 06/30/91	1.3824	0.9940
050034	06/01/90 - 05/31/91	1.2763	0.9883	050168	07/01/90 - 06/30/91	1.6796	0.9982
050036	07/01/90 - 06/30/91	1.6831	0.9986	050170	07/01/90 - 06/30/91	1.4186	0.9912
050038	07/01/90 - 06/30/91	1.3836	0.9917	050172	07/01/90 - 06/30/91	1.3424	0.9916
050039	07/01/90 - 06/30/91	1.6237	0.9968	050174	07/01/90 - 06/30/91	1.6054	0.9982
050040	07/01/90 - 06/30/91	1.0743	0.9700	050175	07/01/90 - 06/30/91	1.3782	0.9908
050041	06/01/90 - 05/31/91	1.2943	0.9812	050177	04/01/90 - 03/31/91	1.2361	0.9949
050042	07/01/90 - 06/30/91	1.2173	0.9718	050179	02/01/90 - 01/31/91	1.2439	0.9875
050045	07/01/90 - 06/30/91	1.2646	0.9780	050181	07/01/90 - 06/30/91	1.3230	0.9723
050046	06/01/90 - 05/31/91	1.1725	0.9727	050183	07/01/90 - 06/30/91	1.1358	0.9837
050047	06/17/90 - 06/16/91	1.6773	0.9982	050188	06/01/90 - 05/31/91	1.3770	0.9897
050051	07/01/90 - 06/30/91	1.1504	0.9759	050191	07/01/90 - 06/30/91	1.3900	0.9725
050054	07/01/90 - 06/30/91	1.2745	0.9970	050192	07/01/90 - 06/30/91	1.1528	0.9812
050055	07/01/90 - 06/30/91	1.2814	0.9935	050193	07/01/90 - 06/30/91	1.3447	0.9893
050056	07/01/90 - 06/30/91	1.3467	0.9954	050194	07/01/90 - 06/30/91	1.3465	0.9917
050057	07/01/90 - 06/30/91	1.4468	0.9928	050195	07/01/90 - 06/30/91	1.4964	0.9964
050063	07/01/90 - 06/30/91	1.3235	0.9936	050197	07/01/90 - 06/30/91	1.8953	0.9979
050065	04/01/90 - 03/31/91	1.5002	0.9957	050199	07/01/90 - 06/30/91	1.3072	0.9870
050066	04/01/90 - 03/31/91	1.2849	0.9942	050207	07/01/90 - 06/30/91	1.2034	0.9920
050067	07/01/90 - 06/30/91	1.2757	0.9800	050213	07/01/90 - 06/30/91	1.3656	0.9908
050068	07/01/90 - 06/30/91	1.1063	0.9913	050215	07/01/90 - 06/30/91	1.4195	0.9980
050069	07/01/90 - 06/30/91	1.5585	0.9930	050219	05/01/90 - 04/30/91	1.3491	0.9873
050077	07/01/90 - 06/30/91	1.6363	0.9990	050220	04/01/90 - 03/31/91	1.2865	0.9918
				050228	07/01/90 - 06/30/91	1.2481	0.9730

Table 9 -- 1991 Transfer Adjusted Case Mix Index and Transfer Adjustment to Discharges for Capital Hospital-Specific Rate Redeterminations

Page 3 of 21

PROVIDER NUMBER	COST REPORTING PERIOD BEGIN - END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES	PROVIDER NUMBER	COST REPORTING PERIOD BEGIN - END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES
050230	03/01/90 - 02/28/91	1.3559	0.9864	050382	07/01/90 - 06/30/91	1.3964	0.9998
050232	07/01/90 - 06/30/91	1.8510	0.9972	050387	07/01/90 - 06/30/91	0.9757	0.9887
050240	07/01/90 - 06/30/91	1.4347	0.9967	050388	07/01/90 - 06/30/91	0.9395	0.9345
050242	07/01/90 - 06/30/91	1.3816	0.9981	050390	07/01/90 - 06/30/91	1.2347	0.9944
050243	07/01/90 - 06/30/91	1.4278	0.9964	050392	07/01/90 - 06/30/91	0.9208	0.9739
050245	07/01/90 - 06/30/91	1.4570	0.9934	050393	07/01/90 - 06/30/91	1.4767	0.9976
050248	07/01/90 - 06/30/91	1.1256	0.9816	050397	07/01/90 - 06/30/91	0.8635	0.9607
050258	03/01/90 - 02/28/91	1.2539	0.9960	050401	05/01/90 - 04/30/91	1.1843	0.9947
050260	07/01/90 - 06/30/91	0.9582	0.9142	050406	07/01/90 - 06/30/91	1.1036	0.9694
050261	07/01/90 - 06/30/91	1.1889	0.9876	050410	07/01/90 - 06/30/91	0.8326	1.0000
050262	07/01/90 - 06/30/91	1.6956	0.9943	050414	04/01/90 - 03/31/91	1.2749	0.9771
050263	05/01/90 - 04/30/91	1.2801	0.9883	050418	06/01/90 - 05/31/91	1.2857	0.9822
050267	07/01/90 - 06/30/91	1.4913	0.9978	050419	07/01/90 - 06/30/91	1.2536	0.9653
050274	07/01/90 - 06/30/91	0.9849	0.9969	050423	04/01/90 - 03/31/91	1.0784	0.9466
050276	07/01/90 - 06/30/91	1.1464	0.9899	050430	07/01/90 - 06/30/91	0.9386	0.9386
050277	07/01/90 - 06/30/91	1.3527	0.9958	050432	06/01/90 - 05/31/91	1.5941	0.9949
050278	06/01/90 - 05/31/91	1.3892	0.9881	050433	07/01/90 - 06/30/91	1.1255	0.9861
050279	07/01/90 - 06/30/91	1.2355	0.9898	050434	04/01/90 - 03/31/91	1.0708	0.9635
050280	07/01/90 - 06/30/91	1.4806	0.9884	050435	07/01/90 - 06/30/91	1.2687	0.9813
050283	07/01/90 - 06/30/91	1.3910	0.9892	050436	07/01/90 - 06/30/91	1.0005	0.9786
050289	07/01/90 - 06/30/91	1.6600	0.9966	050442	06/02/90 - 06/01/91	1.0000	1.0000
050290	06/01/90 - 05/31/91	1.4497	0.9981	050443	07/01/90 - 06/30/91	0.9192	0.9473
050291	07/01/90 - 06/30/91	1.1755	0.9933	050444	07/01/90 - 06/30/91	1.2239	0.9929
050292	07/01/90 - 06/30/91	1.1551	0.9882	050446	07/01/90 - 06/30/91	0.8703	0.9264
050293	07/01/90 - 06/30/91	1.2646	1.0000	050448	02/01/90 - 01/31/91	1.0455	0.9838
050295	07/01/90 - 06/30/91	1.3291	0.9928	050449	07/01/90 - 06/30/91	1.2840	0.9910
050296	07/01/90 - 06/30/91	1.1227	0.9909	050450	07/01/90 - 06/30/91	0.7792	1.0000
050299	04/01/90 - 03/31/91	1.2349	0.9909	050451	07/01/90 - 06/30/91	0.9672	0.9656
050307	06/01/90 - 05/31/91	1.3821	0.9934	050454	07/01/90 - 06/30/91	1.6324	0.9954
050308	07/01/90 - 06/30/91	1.5545	0.9978	050456	07/01/90 - 06/30/91	1.3553	0.9900
050312	06/01/90 - 05/31/91	1.7470	0.9960	050457	07/01/90 - 06/30/91	1.7728	0.9970
050315	07/01/90 - 06/30/91	1.2767	0.9900	050459	07/01/90 - 06/30/91	1.2936	0.9781
050320	07/01/90 - 06/30/91	1.2591	0.9828	050464	06/01/90 - 05/31/91	1.7723	0.9980
050325	07/01/90 - 06/30/91	1.2670	0.9892	050470	07/01/90 - 06/30/91	1.1205	0.9687
050331	03/01/90 - 02/28/91	1.2859	0.9832	050476	07/01/90 - 06/30/91	1.2633	0.9965
050333	07/01/90 - 06/30/91	1.0043	0.9200	050477	07/01/90 - 06/30/91	1.4046	0.9856
050334	07/01/90 - 06/30/91	1.4558	0.9975	050482	07/01/90 - 06/30/91	0.9911	0.9813
050337	06/01/90 - 05/31/91	1.2079	0.9712	050485	07/01/90 - 06/30/91	1.6939	0.9964
050342	07/01/90 - 06/30/91	1.3145	0.9904	050488	07/01/90 - 06/30/91	1.1848	0.9874
050343	07/01/90 - 06/30/91	1.0605	0.9944	050491	07/01/90 - 06/30/91	1.4548	0.9943
050348	07/01/90 - 06/30/91	1.6552	0.9896	050494	07/01/90 - 06/30/91	1.0993	0.9687
050349	07/01/90 - 06/30/91	1.0430	0.9760	050496	07/01/90 - 06/30/91	1.7649	0.9934
050350	07/01/90 - 06/30/91	1.3930	0.9959	050497	07/01/90 - 06/30/91	0.6934	1.0000
050353	07/01/90 - 06/30/91	1.6318	0.9943	050502	07/01/90 - 06/30/91	1.6736	0.9998
050355	07/01/90 - 06/30/91	0.9531	0.9757	050516	04/01/90 - 03/31/91	1.3195	0.9853
050359	07/01/90 - 06/30/91	1.1069	0.9965	050522	06/01/90 - 05/31/91	1.3278	0.9905
050360	07/01/90 - 06/30/91	1.4111	0.9874	050527	07/01/90 - 06/30/91	1.3130	0.9938
050373	07/01/90 - 06/30/91	1.3496	0.9718	050528	07/01/90 - 06/30/91	1.2087	0.9864
050376	07/01/90 - 06/30/91	1.2950	0.9952	050534	06/01/90 - 05/31/91	1.3954	0.9829
050377	07/01/90 - 06/30/91	0.9950	0.9658	050539	07/01/90 - 06/30/91	1.2107	0.9728
050378	06/01/90 - 05/31/91	1.1799	0.9881	050542	07/01/90 - 06/30/91	1.1138	0.9352
050379	07/01/90 - 06/30/91	1.1738	0.9821	050545	07/01/90 - 06/30/91	0.8839	1.0000
050380	07/01/90 - 06/30/91	1.5920	0.9986	050546	07/01/90 - 06/30/91	1.0031	1.0000

Table 9 -- 1991 Transfer Adjusted Case Mix Index and Transfer Adjustment to Discharges for Capital Hospital-Specific Rate Redeterminations

Page 4 of 21

PROVIDER NUMBER	COST REPORTING PERIOD		TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES	PROVIDER NUMBER	COST REPORTING PERIOD		TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES
	BEGIN	END				BEGIN	END		
050547	07/01/90	06/30/91	0.9880	1.0000	060023	06/01/90	05/31/91	1.4293	0.9975
050551	06/01/90	05/31/91	1.2910	0.9855	060024	07/01/90	06/30/91	1.5697	0.9928
050559	07/01/90	06/30/91	1.2847	0.9730	060026	07/01/90	06/30/91	1.3890	0.9948
050564	06/01/90	05/31/91	1.3180	0.9817	060028	06/01/90	05/31/91	1.3139	0.9986
050565	07/01/90	06/30/91	1.1075	0.9827	060031	07/01/90	06/30/91	1.3764	0.9923
050566	07/01/90	06/30/91	1.0079	0.9481	060032	07/01/90	06/30/91	1.3823	0.9998
050568	07/01/90	06/30/91	1.3406	0.9907	060036	04/01/90	03/31/91	1.1774	0.9832
050569	07/01/90	06/30/91	1.1516	0.9809	060054	05/01/90	04/30/91	1.2768	0.9949
050573	07/01/90	06/30/91	1.6228	0.9985	080001	07/01/90	06/30/91	1.5816	0.9992
050577	07/01/90	06/30/91	1.3112	0.9908	080002	07/01/90	06/30/91	1.1584	0.9880
050578	07/01/90	06/30/91	1.4584	0.9608	080003	07/01/90	06/30/91	1.2413	0.9977
050579	06/01/90	05/31/91	1.4135	0.9912	080004	06/25/90	06/24/91	1.2508	0.9965
050581	06/01/90	05/31/91	1.3394	0.9886	080006	07/01/90	06/30/91	1.1346	0.9960
050583	06/01/90	05/31/91	1.6787	0.9974	080007	07/01/90	06/30/91	1.2098	0.9840
050584	06/01/90	05/31/91	1.3001	0.9785	090001	07/01/90	06/30/91	1.4317	0.9981
050589	06/01/90	05/31/91	1.3231	0.9858	090003	07/01/90	06/30/91	1.4300	0.9997
050594	07/01/90	06/30/91	1.9550	0.9930	090004	07/01/90	06/30/91	1.5547	0.9999
050599	07/01/90	06/30/91	1.6169	0.9960	090009	07/01/90	06/30/91	1.2250	0.9994
050601	04/01/90	03/31/91	1.2700	0.9819	090010	07/01/90	06/30/91	0.9677	0.9898
050603	07/01/90	06/30/91	1.4390	0.9971	090011	07/01/90	06/30/91	1.8233	0.9998
050608	02/01/90	01/31/91	1.1688	0.9916	100010	07/01/90	06/30/91	1.3816	0.9951
050613	07/01/90	06/30/91	1.1084	0.9983	100027	06/01/90	05/31/91	0.9253	0.9782
050615	05/01/90	04/30/91	1.4687	0.9968	100032	07/01/90	06/30/91	1.7467	0.9981
050616	07/01/90	06/30/91	1.3375	0.9894	100038	05/01/90	04/30/91	1.5856	0.9968
050618	07/01/90	06/30/91	1.1252	0.9634	100039	07/01/90	06/30/91	1.5889	0.9941
050623	07/01/90	06/30/91	1.0854	1.0000	100059	07/01/90	06/30/91	1.4927	0.9971
050625	04/01/90	03/31/91	1.4670	0.9984	100067	07/01/90	06/30/91	1.4006	0.9949
050633	06/01/90	05/31/91	1.2098	0.9790	100068	04/01/90	03/31/91	1.4001	0.9999
050636	07/01/90	06/30/91	1.2840	0.9754	100070	07/01/90	06/30/91	1.3171	0.9849
050637	05/01/90	04/30/91	1.1806	0.9982	100073	07/01/90	06/30/91	1.8170	0.9984
050638	07/01/90	06/30/91	0.9760	0.9592	100075	07/01/90	06/30/91	1.2990	0.9991
050641	07/01/90	06/30/91	1.1261	0.9963	100076	04/01/90	03/31/91	1.3035	0.9968
050651	02/01/90	01/31/91	1.2891	0.9897	100079	06/01/90	05/31/91	1.1629	0.9795
050660	07/01/90	06/30/91	1.0823	0.9985	100084	07/01/90	06/30/91	1.3182	0.9730
050661	02/01/90	01/31/91	0.8959	0.9909	100086	07/01/90	06/30/91	1.3079	0.9930
050666	07/01/90	06/30/91	0.9562	1.0000	100113	07/01/90	06/30/91	1.8598	0.9993
050667	07/01/90	06/30/91	1.0577	0.9532	100114	04/01/90	03/31/91	1.4365	0.9944
050668	07/01/90	06/30/91	1.1585	0.9556	100122	07/01/90	06/30/91	1.3201	0.9836
050671	07/01/90	06/30/91	1.1314	0.9635	100126	06/01/90	05/31/91	1.4682	0.9926
050672	07/01/90	06/30/91	0.7000	0.9986	100145	07/01/90	06/30/91	1.3802	0.9928
050675	02/01/90	01/31/91	1.5255	0.9945	100160	07/01/90	06/30/91	1.1880	0.9546
050676	07/01/90	06/30/91	0.9866	0.8925	100161	06/01/90	05/31/91	1.5387	0.9849
050678	07/01/90	06/30/91	1.1846	0.9927	100168	07/01/90	06/30/91	1.2893	0.9895
050684	07/01/90	06/30/91	1.2156	0.9800	100172	06/01/90	05/31/91	1.3761	0.9990
050685	07/01/90	06/30/91	1.1570	0.9822	100179	05/01/90	04/30/91	1.6946	0.9978
050688	07/01/90	06/30/91	1.1460	0.9749	100191	07/01/90	06/30/91	1.3657	0.9876
050689	06/01/90	05/31/91	1.3953	0.9714	100200	07/01/90	06/30/91	1.3440	0.9939
060008	07/01/90	06/30/91	1.467	0.9808	100204	03/01/90	02/28/91	1.5362	0.9984
060012	07/01/90	06/30/91	1.4161	0.9988	100207	04/01/90	03/31/91	1.3789	0.9900
060013	07/01/90	06/30/91	1.1979	0.9858	100213	05/01/90	04/30/91	1.6078	0.9973
060015	07/01/90	06/30/91	1.4123	0.9788	100218	07/01/90	06/30/91	0.8880	0.9946
060016	07/01/90	06/30/91	1.1173	0.9730	100225	06/01/90	05/31/91	1.3749	0.9952
060020	07/01/90	06/30/91	1.4487	0.9919	100231	06/01/90	05/31/91	1.6939	0.9984

Table 9 -- 1991 Transfer Adjusted Case Mix Index and Transfer
Adjustment to Discharges for Capital Hospital-Specific
Rate Redeterminations

Page 5 of 21

PROVIDER NUMBER	COST REPORTING PERIOD BEGIN - END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES	PROVIDER NUMBER	COST REPORTING PERIOD BEGIN - END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES
100239	06/01/90 - 05/31/91	1.4130	0.9960	110132	04/01/90 - 03/31/91	1.1336	0.9770
100240	06/01/90 - 05/31/91	0.8715	0.9990	110133	07/01/90 - 06/30/91	0.8958	0.9424
100242	02/01/90 - 01/31/91	1.2996	0.9939	110134	07/01/90 - 06/30/91	0.8687	0.9716
100244	07/01/90 - 06/30/91	1.3472	0.9854	110135	05/01/90 - 04/30/91	1.1775	0.9845
100249	06/01/90 - 05/31/91	1.3032	0.9772	110136	07/01/90 - 06/30/91	1.0711	0.9872
100252	02/01/90 - 01/31/91	1.3099	0.9842	110141	07/01/90 - 06/30/91	0.8945	0.9502
100254	05/01/90 - 04/30/91	1.5618	1.0000	110143	06/01/90 - 05/31/91	1.2569	0.9915
100256	03/01/90 - 02/28/91	1.6566	0.9943	110149	07/01/90 - 06/30/91	1.0577	0.9818
100258	06/01/90 - 05/31/91	1.7111	0.9877	110152	07/01/90 - 06/30/91	1.0516	0.9631
100264	03/01/90 - 02/28/91	1.3496	0.9781	110153	03/01/90 - 02/28/91	1.0129	0.9875
100268	06/01/90 - 05/31/91	1.2892	0.9765	110154	07/01/90 - 06/30/91	0.9935	0.9692
100270	06/01/90 - 05/31/91	0.8943	0.9538	110155	04/01/90 - 03/31/91	1.1040	0.9843
100271	07/01/90 - 06/30/91	1.5335	1.0000	110156	07/01/90 - 06/30/91	0.9377	0.9434
100276	07/01/90 - 06/30/91	1.3435	0.9851	110157	04/01/90 - 03/31/91	1.1274	0.9893
100277	07/01/90 - 06/30/91	1.0014	0.9996	110163	05/01/90 - 04/30/91	1.3225	0.9959
110003	03/01/90 - 02/28/91	1.2541	0.9837	110164	04/01/90 - 03/31/91	1.3061	0.9925
110008	04/01/90 - 03/31/91	1.1292	0.9844	110168	07/01/90 - 06/30/91	1.6267	0.9994
110011	07/01/90 - 06/30/91	1.1499	0.9914	110169	07/01/90 - 06/30/91	0.7899	1.0000
110015	07/01/90 - 06/30/91	1.0642	0.9449	110174	07/01/90 - 06/30/91	0.8584	0.9685
110017	07/01/90 - 06/30/91	0.9171	0.9807	110176	07/01/90 - 06/30/91	1.1772	0.9971
110026	07/01/90 - 06/30/91	1.1143	0.9732	110178	07/01/90 - 06/30/91	1.2734	1.0000
110027	07/01/90 - 06/30/91	1.0537	0.9797	110181	04/01/90 - 03/31/91	0.8988	0.9672
110031	04/01/90 - 03/31/91	1.2851	0.9877	110183	02/01/90 - 01/31/91	1.2711	0.9848
110034	07/01/90 - 06/30/91	1.3837	0.9960	110184	04/01/90 - 03/31/91	1.2015	0.9842
110035	07/01/90 - 06/30/91	1.3294	0.9864	110185	07/01/90 - 06/30/91	0.9922	0.9606
110039	07/01/90 - 06/30/91	1.3043	0.9918	110186	05/01/90 - 04/30/91	1.3079	0.9960
110040	07/01/90 - 06/30/91	0.9304	0.9816	110188	04/01/90 - 03/31/91	1.3662	0.9916
110041	07/01/90 - 06/30/91	1.0706	0.9638	110191	07/01/90 - 06/30/91	1.1392	0.9911
110042	07/01/90 - 06/30/91	1.0522	0.9785	110194	07/01/90 - 06/30/91	0.9021	0.9252
110043	07/01/90 - 06/30/91	1.5517	0.9979	110202	04/01/90 - 03/31/91	1.0218	0.9843
110051	05/01/90 - 04/30/91	1.0464	0.9756	110204	07/01/90 - 06/30/91	0.8977	1.0000
110052	07/01/90 - 06/30/91	0.9413	0.9786	120001	07/01/90 - 06/29/91	1.1611	0.9973
110054	07/01/90 - 06/30/91	1.2266	0.9943	120002	07/01/90 - 06/30/91	1.1676	0.9833
110055	03/01/90 - 02/28/91	0.8844	0.9617	120003	07/01/90 - 06/30/91	1.0629	0.9615
110056	07/01/90 - 06/30/91	1.0169	0.9630	120004	07/01/90 - 06/30/91	1.2318	0.9881
110062	04/01/90 - 03/31/91	0.9073	0.9828	120005	07/01/90 - 06/30/91	1.1798	0.9934
110064	07/01/90 - 06/30/91	1.2220	0.9943	120007	07/01/90 - 06/30/91	1.5746	0.9986
110066	07/01/90 - 06/30/91	1.2402	0.9909	120009	07/01/90 - 06/29/91	0.8718	0.9413
110069	03/01/90 - 02/28/91	1.1888	0.9902	120010	07/01/90 - 06/30/91	1.5315	0.9996
110071	07/01/90 - 06/30/91	1.0509	0.9702	120012	07/01/90 - 06/30/91	0.9189	0.9686
110093	07/01/90 - 06/30/91	0.9273	0.9546	120014	07/01/90 - 06/30/91	1.1690	0.9811
110094	07/01/90 - 06/30/91	1.0365	0.9734	120015	07/01/90 - 06/30/91	0.9507	0.9653
110101	07/01/90 - 06/30/91	1.0162	0.9784	120016	07/01/90 - 06/30/91	0.9569	0.9334
110103	07/01/90 - 06/30/91	0.9375	0.9982	120018	07/01/90 - 06/30/91	1.0198	0.8946
110104	07/01/90 - 06/30/91	1.1572	0.9808	120019	07/01/90 - 06/30/91	1.2130	0.9771
110108	07/01/90 - 06/30/91	0.8679	0.9398	120021	07/01/90 - 06/30/91	0.9481	0.9307
110109	07/01/90 - 06/30/91	1.0859	0.9791	120025	07/01/90 - 06/30/91	0.9026	1.0000
110113	06/01/90 - 05/31/91	0.9838	0.9615	120026	07/01/90 - 06/30/91	1.2954	0.9944
110118	05/01/90 - 04/30/91	1.0455	0.9934	120027	07/01/90 - 06/30/91	1.2766	0.9961
110124	07/01/90 - 06/30/91	1.0531	0.9860	130003	07/01/90 - 06/30/91	1.2441	0.9801
110125	05/01/90 - 04/30/91	1.1444	0.9833	130007	06/01/90 - 05/31/91	1.4950	0.9878
110127	07/01/90 - 06/30/91	0.9496	0.9580	130008	07/01/90 - 06/30/91	0.8650	0.9787
110128	07/01/90 - 06/30/91	1.1458	0.9913	130013	07/01/90 - 06/30/91	1.2388	0.9840

Table 9 -- 1991 Transfer Adjusted Case Mix Index and Transfer
Adjustment to Discharges for Capital Hospital-Specific
Rate Redeterminations

Page 6 of 21

PROVIDER NUMBER	COST REPORTING PERIOD BEGIN - END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES	PROVIDER NUMBER	COST REPORTING PERIOD BEGIN - END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES
130017	07/01/90 - 06/30/91	0.9497	0.9682	140119	07/01/90 - 06/30/91	1.6225	0.9935
130022	07/01/90 - 06/30/91	1.1469	0.9718	140120	05/01/90 - 06/30/91	1.1540	0.9801
130029	07/01/90 - 06/30/91	0.9822	0.9523	140121	07/01/90 - 06/30/91	0.9590	0.9890
130035	07/01/90 - 06/30/91	0.9812	0.9513	140127	07/01/90 - 06/30/91	1.2620	0.9853
130048	07/01/90 - 06/30/91	0.9891	0.9794	140133	07/01/90 - 06/30/91	1.3341	0.9888
140001	07/01/90 - 06/30/91	1.2625	0.9790	140138	07/01/90 - 06/30/91	1.1226	0.9597
140003	03/01/90 - 02/28/91	0.9531	0.9565	140140	07/01/90 - 06/30/91	1.0470	0.9745
140005	04/01/90 - 03/31/91	0.9086	0.9634	140144	04/01/90 - 03/31/91	0.9880	0.9784
140011	04/01/90 - 03/31/91	1.1000	0.9872	140145	07/01/90 - 06/30/91	1.0405	0.9739
140014	07/01/90 - 06/30/91	1.0680	0.9615	140146	05/01/90 - 04/30/91	0.9139	0.9579
140016	03/01/90 - 02/28/91	1.0015	0.9464	140150	07/01/90 - 06/30/91	1.3414	0.9727
140018	07/01/90 - 06/30/91	1.3825	0.9971	140151	07/01/90 - 06/30/91	1.0772	1.0000
140024	07/01/90 - 06/30/91	0.9846	0.9739	140158	07/01/90 - 06/30/91	1.4364	0.9984
140025	04/01/90 - 03/31/91	1.0949	0.9655	140159	07/01/90 - 06/30/91	1.1803	0.9932
140026	07/01/90 - 06/30/91	1.1280	0.9924	140164	04/01/90 - 03/31/91	1.2499	0.9866
140027	05/01/90 - 04/30/91	1.0857	0.9857	140165	04/01/90 - 03/31/91	1.0697	0.9573
140030	05/01/90 - 04/30/91	1.4864	0.9968	140166	07/01/90 - 06/30/91	1.2561	0.9858
140032	07/01/90 - 06/30/91	1.2879	0.9810	140168	07/01/90 - 06/30/91	1.1759	0.9733
140035	07/01/90 - 06/30/91	1.0059	0.9809	140170	07/01/90 - 06/30/91	0.9486	0.9660
140037	07/01/90 - 06/30/91	0.9764	0.9588	140171	07/01/90 - 06/30/91	0.8433	0.9826
140038	05/01/90 - 04/30/91	0.9986	0.9782	140172	07/01/90 - 06/30/91	1.4939	0.9876
140040	05/01/90 - 04/30/91	1.2435	0.9887	140173	07/01/90 - 06/30/91	0.9694	0.9641
140041	06/01/90 - 05/31/91	1.0349	0.9816	140174	07/01/90 - 06/30/91	1.3286	0.9936
140042	04/01/90 - 03/31/91	1.0403	0.9761	140177	04/01/90 - 03/31/91	1.2660	0.9842
140043	05/01/90 - 04/30/91	1.1614	0.9885	140179	07/01/90 - 06/30/91	1.2512	0.9927
140045	07/01/90 - 06/30/91	0.9380	0.9574	140184	05/01/90 - 04/30/91	1.1516	0.9750
140047	05/01/90 - 04/30/91	1.0454	0.9764	140187	07/01/90 - 06/30/91	1.4172	0.9915
140053	07/01/90 - 06/30/91	1.7141	0.9981	140189	07/01/90 - 06/30/91	1.1711	0.9827
140055	05/01/90 - 04/30/91	0.9679	0.9522	140190	05/01/90 - 04/30/91	1.1778	0.9627
140059	07/01/90 - 06/30/91	1.0708	0.9751	140193	07/01/90 - 06/30/91	0.9716	0.9600
140061	07/01/90 - 06/30/91	1.0903	0.9629	140199	07/01/90 - 06/30/91	1.0005	0.9643
140063	07/01/90 - 06/30/91	1.2859	0.9934	140200	07/01/90 - 06/30/91	1.4470	0.9967
140068	04/01/90 - 03/31/91	1.2469	0.9910	140205	06/01/90 - 05/31/91	0.9464	0.9728
140069	05/01/90 - 04/30/91	1.0658	0.9660	140210	05/01/90 - 04/30/91	1.0545	0.9744
140070	05/01/90 - 04/30/91	1.2542	0.9821	140213	04/01/90 - 03/31/91	1.2028	0.9907
140072	07/01/90 - 06/30/91	1.1325	0.9930	140215	07/01/90 - 06/30/91	1.0217	0.9811
140075	07/01/90 - 06/30/91	1.3837	0.9972	140218	07/01/90 - 06/30/91	0.9701	0.9695
140077	05/01/90 - 04/30/91	1.1258	0.9982	140223	07/01/90 - 06/30/91	1.4899	0.9970
140081	07/01/90 - 06/30/91	1.1398	0.9726	140224	07/01/90 - 06/30/91	1.3180	0.9987
140082	06/25/90 - 06/30/91	1.2353	0.9952	140228	06/01/90 - 05/31/91	1.5122	0.9986
140083	07/01/90 - 06/30/91	1.2504	0.9949	140229	05/01/90 - 04/30/91	0.9841	0.9671
140086	07/01/90 - 06/30/91	1.1064	0.9733	140231	07/01/90 - 06/30/91	0.9419	0.9618
140088	07/01/90 - 06/30/91	1.4748	0.9967	140234	07/01/90 - 06/30/91	1.4738	0.9871
140089	07/01/90 - 06/30/91	1.2439	0.9805	140239	03/01/90 - 02/28/91	1.1549	0.9865
140091	07/01/90 - 06/30/91	1.6428	0.9980	140242	07/01/90 - 06/30/91	1.5307	0.9954
140100	07/01/90 - 06/30/91	1.2348	0.9829	140245	07/01/90 - 06/30/91	1.3990	0.9963
140102	07/01/90 - 06/30/91	0.9977	0.9579	140246	07/01/90 - 06/30/91	1.0259	0.9721
140109	07/01/90 - 06/30/91	1.1105	0.9630	140250	05/01/90 - 04/30/91	1.0184	0.9750
140110	05/01/90 - 04/30/91	1.1867	0.9766	140251	07/01/90 - 06/30/91	1.2229	0.9853
140114	02/01/90 - 01/31/91	1.2307	0.9900	140256	04/01/90 - 03/31/91	1.2785	0.9916
140115	07/01/90 - 06/30/91	1.2003	0.9979	140267	07/01/90 - 06/30/91	1.1947	0.9947
140116	07/01/90 - 06/30/91	1.2356	0.9863	140280	06/01/90 - 05/31/91	2.0017	0.9982
140117	07/01/90 - 06/30/91	1.2706	0.9892			1.1627	0.9847

Table 9 -- 1991 Transfer Adjusted Case Mix Index and Transfer Adjustment to Discharges for Capital Hospital-Specific Rate Redeterminations

PROVIDER NUMBER	COST REPORTING PERIOD BEGIN - END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES	PROVIDER NUMBER	COST REPORTING PERIOD BEGIN - END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES
140286	05/01/90 - 04/30/91	1.0958	0.9836	160039	07/01/90 - 06/30/91	1.0594	0.9639
140297	06/01/90 - 05/31/91	1.4644	0.9922	160040	07/01/90 - 06/30/91	1.3683	0.9906
140299	07/01/90 - 06/30/91	0.9061	0.9600	160041	07/01/90 - 06/30/91	1.1307	0.9252
150011	07/01/90 - 06/30/91	1.2054	0.9904	160043	07/01/90 - 06/30/91	0.9522	0.9537
150012	06/01/90 - 05/31/91	1.5356	0.9972	160046	07/01/90 - 06/30/91	1.0361	0.9846
150014	07/01/90 - 06/30/91	1.3162	0.9906	160048	07/01/90 - 06/30/91	1.0502	0.9558
150019	07/01/90 - 06/30/91	1.1806	0.9942	160049	07/01/90 - 06/30/91	0.8964	0.9403
150025	07/01/90 - 06/30/91	1.5000	0.9959	160050	07/01/90 - 06/30/91	1.0265	0.9540
150032	07/01/90 - 06/30/91	1.6723	0.9923	160052	07/01/90 - 06/30/91	1.0132	0.9368
150043	05/01/90 - 06/30/91	1.0463	0.9689	160054	07/01/90 - 06/30/91	1.0667	0.9753
150046	05/01/90 - 06/30/91	1.4368	0.9974	160055	07/01/90 - 06/30/91	1.0381	0.9671
150056	03/01/90 - 02/28/91	1.6483	0.9986	160056	07/01/90 - 06/30/91	1.0472	0.9611
150076	06/01/90 - 05/31/91	1.0106	0.9825	160057	07/01/90 - 06/30/91	1.3664	0.9768
150077	07/01/90 - 06/30/91	1.1483	0.9884	160058	07/01/90 - 06/30/91	1.5856	0.9989
150082	05/01/90 - 04/30/91	1.3756	0.9992	160059	07/01/90 - 06/30/91	1.2447	0.9822
150084	06/01/90 - 06/30/91	1.6502	0.9998	160060	07/01/90 - 06/30/91	1.0670	0.9442
150085	06/01/90 - 05/31/91	0.9815	0.9600	160061	07/01/90 - 06/30/91	0.9750	0.9713
150088	06/01/90 - 05/31/91	1.1415	0.9869	160062	07/01/90 - 06/30/91	0.9466	0.9466
150089	07/01/90 - 06/30/91	1.2727	0.9997	160063	07/01/90 - 06/30/91	1.0822	0.9482
150090	07/01/90 - 06/30/91	1.2749	0.9851	160064	07/01/90 - 06/30/91	1.5155	0.9922
150099	07/01/90 - 06/30/91	1.3224	0.9979	160065	06/01/90 - 05/31/91	1.1304	0.9587
150100	07/01/90 - 06/30/91	1.5650	0.9934	160066	07/01/90 - 06/30/91	1.0695	0.9644
150103	07/01/90 - 06/30/91	1.1350	0.9475	160067	07/01/90 - 06/30/91	1.2389	0.9870
150110	05/01/90 - 04/30/91	0.8663	0.9669	160068	07/01/90 - 06/30/91	1.0828	0.9609
150115	07/01/90 - 06/30/91	1.2561	0.9801	160069	07/01/90 - 06/30/91	1.3270	0.9960
150125	07/01/90 - 06/30/91	1.4009	0.9982	160070	07/01/90 - 06/30/91	1.0843	0.9953
150126	07/01/90 - 06/30/91	1.5552	0.9942	160073	07/01/90 - 06/30/91	0.9085	0.9799
150130	07/01/90 - 06/30/91	1.0930	0.9845	160074	07/01/90 - 06/30/91	1.0137	0.9658
150135	07/01/90 - 06/30/91	0.8724	0.7790	160075	07/01/90 - 06/30/91	1.0738	0.9621
160005	07/01/90 - 06/30/91	1.1284	0.9771	160076	07/01/90 - 06/30/91	0.9634	0.9658
160007	07/01/90 - 06/30/91	0.9942	0.9252	160077	07/01/90 - 06/30/91	1.0967	0.9650
160009	07/01/90 - 06/30/91	1.1264	0.9597	160079	07/01/90 - 06/30/91	1.2936	0.9944
160012	07/01/90 - 06/30/91	1.2010	0.9729	160080	07/01/90 - 06/30/91	1.1280	0.9771
160013	07/01/90 - 06/30/91	1.2253	0.9875	160081	07/01/90 - 06/30/91	1.0805	0.9557
160014	07/01/90 - 06/30/91	0.9644	0.9450	160083	07/01/90 - 06/30/91	1.5385	0.9984
160016	07/01/90 - 06/30/91	1.2801	0.9727	160085	07/01/90 - 06/30/91	1.1202	0.9507
160018	07/01/90 - 06/30/91	0.9963	0.9455	160086	07/01/90 - 06/30/91	0.9972	0.9558
160020	07/01/90 - 06/30/91	1.0889	0.9799	160088	07/01/90 - 06/30/91	1.1967	0.9668
160021	07/01/90 - 06/30/91	1.1383	0.9704	160089	04/01/90 - 03/31/91	1.0765	0.9782
160023	07/01/90 - 06/30/91	1.0926	0.9576	160091	07/01/90 - 06/30/91	1.1241	0.9684
160025	07/01/90 - 06/30/91	1.7993	0.9964	160093	07/01/90 - 06/30/91	1.0441	0.9509
160026	07/01/90 - 06/30/91	1.0176	0.9654	160094	07/01/90 - 06/30/91	1.1848	0.9607
160027	07/01/90 - 06/30/91	1.1020	0.9658	160095	07/01/90 - 06/30/91	1.0452	0.9522
160028	07/01/90 - 06/30/91	1.2532	0.9929	160097	07/01/90 - 06/30/91	1.1179	0.9726
160029	07/01/90 - 06/30/91	1.4286	0.9984	160098	07/01/90 - 06/30/91	0.9759	0.9767
160030	07/01/90 - 06/30/91	1.3156	0.9862	160101	07/01/90 - 06/30/91	1.2025	0.9656
160031	07/01/90 - 06/30/91	1.0430	0.9428	160102	07/01/90 - 06/30/91	1.4498	0.9972
160032	07/01/90 - 06/30/91	1.0381	0.9719	160103	07/01/90 - 06/30/91	1.0879	0.9531
160033	07/01/90 - 06/30/91	1.3362	0.9914	160106	07/01/90 - 06/30/91	1.0484	0.9539
160034	07/01/90 - 06/30/91	1.0004	0.9513	160107	07/01/90 - 06/30/91	1.1084	0.9397
160035	07/01/90 - 06/30/91	0.9167	0.8895	160108	07/01/90 - 06/30/91	1.1588	0.9690
160036	07/01/90 - 06/30/91	1.0264	0.9643	160109	07/01/90 - 06/30/91	0.9842	0.9575
160037	07/01/90 - 06/30/91	1.0090	0.9454				

Table 9 -- 1991 Transfer Adjusted Case Mix Index and Transfer Adjustment to Discharges for Capital Hospital-Specific Rate Redeterminations

Page 8 of 21

PROVIDER NUMBER	COST REPORTING PERIOD BEGIN	COST REPORTING PERIOD END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES	PROVIDER NUMBER	COST REPORTING PERIOD BEGIN	COST REPORTING PERIOD END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES
160112	07/01/90	06/30/91	1.3473	0.9729	170095	07/01/90	06/30/91	1.1595	0.9755
160113	07/01/90	06/30/91	1.0284	0.9757	170100	05/01/90	04/30/91	0.8024	0.9605
160114	07/01/90	06/30/91	1.0111	0.9677	170103	07/01/90	06/30/91	1.1985	0.9741
160115	07/01/90	06/30/91	1.0240	0.9746	170105	07/01/90	06/30/91	0.9727	0.9646
160116	07/01/90	06/30/91	1.1182	0.9779	170115	07/01/90	06/30/91	1.0944	0.9777
160117	07/01/90	06/30/91	1.3380	0.9970	170133	07/01/90	06/30/91	1.1972	0.9787
160118	07/01/90	06/30/91	0.9921	0.9804	170140	07/01/90	06/30/91	1.0051	0.9631
160119	07/01/90	06/30/91	0.8414	0.9528	170142	07/01/90	06/30/91	1.2524	0.9808
160120	07/01/90	06/30/91	1.0122	0.9074	170159	07/01/90	06/30/91	0.9249	0.9530
160123	07/01/90	06/30/91	1.1013	0.9674	170171	06/01/90	05/31/91	1.1739	0.9905
160124	07/01/90	06/30/91	1.1725	0.9555	180002	07/01/90	06/30/91	1.1371	0.9787
160126	03/01/90	02/28/91	1.0646	0.9726	180005	07/01/90	06/30/91	1.0570	0.9808
160134	07/01/90	06/30/91	0.8913	0.9033	180006	05/01/90	04/30/91	0.9283	0.9958
160135	07/01/90	06/30/91	0.9984	0.9685	180007	07/01/90	06/30/91	0.9957	0.9957
160140	07/01/90	06/30/91	1.0695	0.9707	180012	07/01/90	06/30/91	1.3870	0.9912
160141	07/01/90	06/30/91	0.9299	0.9637	180013	04/01/90	03/31/91	1.3472	0.9942
160142	07/01/90	06/30/91	1.1277	0.9349	180018	07/01/90	06/30/91	1.1808	0.9760
160143	07/01/90	06/30/91	1.0324	0.9917	180020	07/01/90	06/30/91	1.0054	0.9710
160145	07/01/90	06/30/91	1.0959	0.9932	180021	07/01/90	06/30/91	0.9139	0.9757
160146	07/01/90	06/30/91	1.3035	0.9837	180024	07/01/90	06/30/91	1.1659	0.9688
160151	07/01/90	06/30/91	1.1043	0.9857	180027	04/01/90	03/31/91	1.1265	0.9784
160152	07/01/90	06/30/91	1.0531	0.9558	180028	07/01/90	06/30/91	0.9975	0.9634
160153	07/01/90	06/30/91	1.5418	0.9979	180029	07/01/90	06/30/91	1.2749	0.9842
170003	07/01/90	06/30/91	1.2184	0.9869	180032	05/01/90	04/30/91	0.9409	0.9710
170007	07/01/90	06/30/91	1.1130	0.9945	180033	07/01/90	06/30/91	1.0612	0.9390
170009	06/01/90	05/31/91	1.1753	0.9952	180034	07/01/90	06/30/91	1.0579	0.9643
170010	07/01/90	06/30/91	1.1517	0.9711	180038	06/01/90	05/31/91	1.3029	0.9934
170011	07/01/90	06/30/91	1.3391	0.9891	180042	07/01/90	06/30/91	1.0424	0.9517
170013	07/01/90	06/30/91	1.2178	0.9937	180046	07/01/90	06/30/91	1.0433	0.9629
170015	04/01/90	03/31/91	1.0691	0.9763	180047	07/01/90	06/30/91	1.0074	0.9273
170016	06/01/90	05/31/91	1.5642	0.9981	180049	07/01/90	06/30/91	1.3477	0.9735
170020	07/01/90	06/30/91	1.2261	0.9805	180050	07/01/90	06/30/91	1.2956	0.9617
170025	07/01/90	06/30/91	1.3852	0.9868	180053	07/01/90	06/30/91	1.1763	0.9753
170037	07/01/90	06/30/91	1.1576	0.9800	180054	07/01/90	06/30/91	1.0916	0.9622
170040	07/01/90	06/30/91	1.3762	0.9942	180055	07/01/90	06/30/91	1.0289	0.9766
170044	07/01/90	06/30/91	1.2031	0.9832	180056	07/01/90	06/30/91	1.0490	0.9817
170045	07/01/90	06/30/91	1.0186	0.9745	180062	07/01/90	06/30/91	0.8157	0.9427
170051	05/01/90	04/30/91	0.9891	0.9608	180065	07/01/90	06/30/91	0.9780	0.9831
170052	05/01/90	04/30/91	1.1198	0.9714	180067	07/01/90	06/30/91	1.8398	0.9970
170053	04/01/90	03/31/91	0.8675	0.9755	180069	07/01/90	06/30/91	1.0985	0.9838
170056	04/01/90	03/31/91	0.9714	0.9742	180070	07/01/90	06/30/91	1.0591	0.9746
170057	07/01/90	06/30/91	1.0163	0.9994	180075	05/01/90	04/30/91	0.9552	0.9793
170058	07/01/90	06/30/91	1.0155	0.9840	180087	07/01/90	06/30/91	0.9767	0.9830
170060	07/01/90	06/30/91	1.0476	0.9737	180092	07/01/90	06/30/91	1.1226	0.9802
170061	04/01/90	03/31/91	1.0099	0.9570	180101	03/01/90	02/28/91	1.2362	0.9840
170067	07/01/90	06/30/91	1.0297	0.9478	180105	03/01/90	02/28/91	0.9490	0.9665
170069	07/01/90	06/30/91	0.8604	0.9586	180108	07/01/90	06/30/91	0.9097	0.9624
170072	04/01/90	03/31/91	0.9652	0.9660	180117	06/01/90	05/31/91	1.2858	0.9623
170074	05/01/90	04/30/91	1.1516	0.9919	180118	07/01/90	06/30/91	0.9816	0.9610
170084	07/01/90	06/30/91	0.9469	0.9366	180122	07/01/90	06/30/91	0.9400	0.9328
170085	07/01/90	06/30/91	0.9418	0.9079	180125	07/01/90	06/30/91	0.9963	0.9721
170089	07/01/90	06/30/91	0.9941	0.9319	180129	05/01/90	04/30/91	1.1048	0.9717
170093	04/01/90	03/31/91	1.0160	0.9449	180134	07/01/90	06/30/91	1.1039	0.9564

Table 9 -- 1991 Transfer Adjusted Case Mix Index and Transfer
Adjustment to Discharges for Capital Hospital-Specific
Rate Redeterminations

Page 9 of 21

PROVIDER NUMBER	COST REPORTING PERIOD BEGIN - END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES	PROVIDER NUMBER	COST REPORTING PERIOD BEGIN - END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES
180139	07/01/90 - 06/30/91	1.0016	0.9699	190187	05/01/90 - 04/30/91	0.6504	0.9217
190001	07/01/90 - 06/30/91	0.8920	0.9937	190190	04/01/90 - 03/31/91	1.0107	0.9722
190005	07/01/90 - 06/30/91	1.2688	0.9972	190196	05/01/90 - 04/30/91	0.8320	1.0000
190006	07/01/90 - 06/30/91	1.0634	0.9967	190199	07/01/90 - 06/30/91	1.2505	0.9787
190007	07/01/90 - 06/30/91	1.0531	0.9663	190204	06/01/90 - 05/31/91	1.4451	0.9964
190008	04/01/90 - 03/31/91	1.4522	0.9997	200002	05/01/90 - 04/30/91	1.0542	0.9698
190009	07/01/90 - 06/30/91	1.1074	0.9976	200003	07/01/90 - 06/30/91	1.0322	0.9767
190010	07/01/90 - 06/30/91	0.9037	0.9825	200008	07/01/90 - 06/30/91	1.1920	0.9959
190011	07/01/90 - 06/30/91	1.0769	0.9972	200012	07/01/90 - 06/30/91	1.1141	0.9802
190015	07/01/90 - 06/30/91	1.1941	0.9907	200013	07/01/90 - 06/30/91	1.1370	0.9857
190017	07/01/90 - 06/30/91	1.1949	0.9873	200015	07/01/90 - 06/30/91	1.2617	0.9899
190019	07/01/90 - 06/30/91	1.4884	0.9980	200016	07/01/90 - 06/30/91	1.0241	0.9669
190020	07/01/90 - 06/30/91	1.1401	0.9805	200019	05/01/90 - 04/30/91	1.2045	0.9919
190023	07/01/90 - 06/30/91	0.8858	0.9699	200020	07/01/90 - 06/30/91	1.0464	0.9903
190027	07/01/90 - 06/30/91	1.4165	0.9970	200023	04/01/90 - 03/31/91	0.8545	0.9776
190029	07/01/90 - 06/30/91	1.2454	0.9527	200024	07/01/90 - 06/30/91	1.1784	0.9890
190033	06/01/90 - 05/31/91	0.9779	0.9904	200037	07/01/90 - 06/30/91	1.1593	0.9735
190035	07/01/90 - 06/30/91	1.4151	1.0000	200038	05/01/90 - 04/30/91	1.0173	0.9803
190036	05/01/90 - 04/30/91	1.6235	0.9994	200039	04/01/90 - 03/31/91	1.2975	0.9941
190037	07/01/90 - 06/30/91	0.9822	0.9600	200040	06/01/90 - 05/31/91	1.0690	0.9706
190041	07/01/90 - 06/30/91	1.5365	0.9979	200050	07/01/90 - 06/30/91	1.1297	0.9837
190045	07/01/90 - 06/30/91	1.2905	0.9884	200051	07/01/90 - 06/30/91	0.9872	0.9559
190047	07/01/90 - 06/30/91	1.1614	0.9775	200063	04/01/90 - 03/31/91	1.2307	0.9854
190048	07/01/90 - 06/30/91	0.9738	0.9779	210001	07/01/90 - 06/30/91	1.3065	0.9998
190054	07/01/90 - 06/30/91	1.4017	0.9824	210002	07/01/90 - 06/30/91	1.7811	0.9998
190071	07/01/90 - 06/30/91	0.9224	0.9754	210003	07/01/90 - 06/30/91	1.3074	0.9941
190075	07/01/90 - 06/30/91	1.4096	0.9970	210004	07/01/90 - 06/30/91	1.2490	0.9915
190081	07/01/90 - 06/30/91	0.8500	0.9468	210005	07/01/90 - 06/30/91	1.2099	0.9914
190086	05/01/90 - 04/30/91	1.2121	0.9885	210007	07/01/90 - 06/30/91	1.4036	0.9993
190098	07/01/90 - 06/30/91	1.3357	1.0000	210008	07/01/90 - 06/30/91	1.2721	0.9983
190103	05/01/90 - 04/30/91	0.9457	0.9828	210009	07/01/90 - 06/30/91	1.5349	0.9996
190112	06/01/90 - 05/31/91	1.2993	0.9930	210010	07/01/90 - 06/30/91	1.1546	0.9749
190114	07/01/90 - 06/30/91	0.9262	0.9908	210012	07/01/90 - 06/30/91	1.4363	0.9958
190122	07/01/90 - 06/30/91	1.1690	0.9943	210013	07/01/90 - 06/30/91	1.2859	0.9966
190124	07/01/90 - 06/30/91	1.4200	1.0000	210015	07/01/90 - 06/30/91	1.2214	0.9943
190131	07/01/90 - 06/30/91	1.2679	0.9836	210016	07/01/90 - 06/30/91	1.7256	0.9981
190132	07/01/90 - 06/30/91	1.0926	0.9656	210017	07/01/90 - 06/30/91	1.1532	0.9803
190133	06/01/90 - 05/31/91	1.0310	0.9721	210018	07/01/90 - 06/30/91	1.2356	0.9918
190138	05/01/90 - 04/30/91	0.7693	0.9971	210019	07/01/90 - 06/30/91	1.3193	0.9995
190140	05/01/90 - 04/30/91	0.9928	0.9748	210021	07/01/90 - 06/30/91	1.2474	0.9949
190148	06/01/90 - 05/31/91	0.9603	0.9739	210022	07/01/90 - 06/30/91	1.2865	0.9893
190152	06/01/90 - 05/31/91	1.4353	0.9909	210023	07/01/90 - 06/30/91	1.2659	0.9894
190155	07/01/90 - 06/30/91	0.9519	0.9823	210024	07/01/90 - 06/30/91	1.2563	0.9983
190156	07/01/90 - 06/30/91	0.8431	0.9688	210025	07/01/90 - 06/30/91	1.2417	0.9942
190158	06/01/90 - 05/31/91	1.3173	0.9986	210026	07/01/90 - 06/30/91	1.3293	0.9954
190161	07/01/90 - 06/30/91	0.8502	1.0000	210027	07/01/90 - 06/30/91	1.2174	0.9924
190166	05/01/90 - 04/30/91	1.0267	0.9499	210028	07/01/90 - 06/30/91	1.0342	0.9766
190170	04/01/90 - 03/31/91	1.0066	0.9889	210029	07/01/90 - 06/30/91	1.3281	0.9823
190173	06/01/90 - 05/31/91	1.4328	0.9957	210030	07/01/90 - 06/30/91	1.0597	0.9859
190176	07/01/90 - 06/30/91	1.3967	0.9984	210031	07/01/90 - 06/30/91	1.4101	1.0000
190182	03/01/90 - 02/28/91	1.0245	0.9959	210032	07/01/90 - 06/30/91	1.1851	0.9960
190183	07/01/90 - 06/30/91	1.0589	0.9984	210033	07/01/90 - 06/30/91	1.1332	0.9957
				210034	07/01/90 - 06/30/91	1.1874	0.9961

Table 9 -- 1991 Transfer Adjusted Case Mix Index and Transfer Adjustment to Discharges for Capital Hospital-Specific Rate Redeterminations

PROVIDER NUMBER	COST REPORTING PERIOD BEGIN	COST REPORTING PERIOD END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES	PROVIDER NUMBER	COST REPORTING PERIOD BEGIN	COST REPORTING PERIOD END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES
210035	07/01/90	06/30/91	1.1340	0.9942	230060	07/01/90	06/30/91	1.1735	0.9882
210036	07/01/90	06/30/91	1.1601	0.9897	230062	07/01/90	06/30/91	1.0550	0.9605
210037	07/01/90	06/30/91	1.1898	0.9906	230066	04/01/90	03/31/91	1.3065	0.9931
210038	07/01/90	06/30/91	1.3667	0.9956	230068	07/01/90	06/30/91	1.2994	0.9986
210039	07/01/90	06/30/91	1.1915	0.9893	230069	07/01/90	06/30/91	1.1071	0.9820
210040	07/01/90	06/30/91	1.3274	0.9897	230070	07/01/90	06/30/91	1.2974	0.9904
210043	07/01/90	06/30/91	1.1730	1.0000	230072	04/01/90	03/31/91	1.1920	0.9998
210044	07/01/90	06/30/91	1.1968	0.9966	230075	07/01/90	06/30/91	1.3133	0.9895
210045	07/01/90	06/30/91	0.9828	0.9707	230077	07/01/90	06/30/91	2.1198	0.9982
210046	07/01/90	06/30/91	1.1161	0.9929	230081	07/01/90	06/30/91	1.1623	0.9890
210048	07/01/90	06/30/91	1.1597	0.9915	230082	07/01/90	06/30/91	1.1530	0.9759
210051	07/01/90	06/30/91	1.2746	0.9963	230085	07/01/90	06/30/91	1.1395	0.9726
210054	07/01/90	06/30/91	1.2398	0.9927	230086	07/01/90	06/30/91	0.9444	0.9582
210055	07/01/90	06/30/91	1.1891	0.9949	230092	07/01/90	06/30/91	1.2447	0.9860
210056	07/01/90	06/30/91	1.3635	0.9927	230093	07/01/90	06/30/91	1.1758	0.9815
210057	07/01/90	06/30/91	1.2376	0.9921	230095	04/01/90	03/31/91	1.0916	0.9743
210058	07/01/90	06/30/91	1.7267	0.9749	230097	07/01/90	06/30/91	1.4659	0.9982
210059	07/01/90	06/30/91	1.3274	0.9943	230099	07/01/90	06/30/91	1.2030	0.9921
220011	07/01/90	06/30/91	1.1694	0.9946	230100	07/01/90	06/30/91	1.1529	0.9754
220041	07/01/90	06/30/91	1.1662	0.9897	230106	07/01/90	06/30/91	1.0858	0.9780
220083	07/01/90	06/30/91	1.1349	0.9951	230108	07/01/90	06/30/91	1.1589	0.9826
220114	07/01/90	06/30/91	1.0456	0.9962	230111	07/01/90	06/30/91	0.9995	0.9753
220115	07/01/90	06/30/91	1.3012	0.9942	230113	07/01/90	06/30/91	1.0017	0.9772
220131	07/01/90	06/30/91	1.1599	0.9804	230116	04/01/90	03/31/91	0.9398	0.9727
220133	07/01/90	06/30/91	0.7435	0.9594	230117	07/01/90	06/30/91	0.9989	0.9954
220153	07/01/90	06/30/91	1.0720	0.9518	230120	07/01/90	06/30/91	1.0076	0.9989
220154	07/01/90	06/30/91	0.9595	0.9472	230124	04/01/90	03/31/91	1.1021	0.9954
220163	07/01/90	06/30/91	1.9736	0.9976	230132	07/01/90	06/30/91	1.3156	0.9810
230001	07/01/90	06/30/91	1.1589	0.9747	230133	07/01/90	06/30/91	1.0997	0.9839
230002	07/01/90	06/30/91	1.2389	0.9909	230140	07/01/90	06/30/91	1.2608	0.9982
230004	07/01/90	06/30/91	1.6683	0.9975	230144	07/01/90	06/30/91	1.1596	0.9949
230005	07/01/90	06/30/91	1.9337	0.9881	230147	07/01/90	06/30/91	1.4790	0.9988
230006	04/01/90	03/31/91	0.9901	0.9782	230153	07/01/90	06/30/91	1.0730	0.9761
230014	07/01/90	06/30/91	0.9487	0.9851	230154	07/01/90	06/30/91	1.0836	0.9954
230019	07/01/90	06/30/91	1.5564	0.9990	230156	07/01/90	06/30/91	1.6313	0.9993
230024	07/01/90	06/30/91	1.4711	0.9989	230157	07/01/90	06/30/91	1.4088	0.9892
230027	07/01/90	06/30/91	1.0871	0.9780	230162	04/01/90	03/31/91	0.9233	0.9588
230029	07/01/90	06/30/91	1.4890	0.9988	230165	06/24/90	06/23/91	1.6842	0.9993
230030	07/01/90	06/30/91	1.1671	0.9860	230172	04/01/90	03/31/91	1.1553	0.9761
230031	07/01/90	06/30/91	1.3634	0.9927	230173	07/01/90	06/30/91	1.4160	0.9900
230032	07/01/90	06/30/91	1.6846	0.9995	230174	07/01/90	06/30/91	1.2352	1.0000
230034	04/01/90	03/31/91	1.1818	0.9803	230178	04/01/90	03/31/91	1.1268	0.9806
230035	07/01/90	06/30/91	1.1484	0.9708	230180	07/01/90	06/30/91	1.1255	0.9992
230036	07/01/90	06/30/91	1.2662	0.9775	230188	07/01/90	06/30/91	1.1440	0.9912
230037	07/01/90	06/30/91	1.2883	0.9780	230189	04/01/90	03/31/91	0.9047	0.9741
230038	07/01/90	06/30/91	1.5364	0.9998	230199	07/01/90	06/30/91	1.1575	0.9874
230039	07/01/90	06/30/91	1.2783	0.9994	230201	07/01/90	06/30/91	0.9530	0.9576
230041	07/01/90	06/30/91	1.1225	0.9953	230207	07/01/90	06/30/91	1.2793	0.9989
230046	07/01/90	06/30/91	1.6964	0.9996	230219	04/01/90	03/31/91	0.9288	0.9426
230047	07/01/90	06/30/91	1.2270	0.9886	230221	04/01/90	03/31/91	1.2339	0.9964
230054	07/01/90	06/30/91	1.5833	0.9980	230222	07/01/90	06/30/91	1.3200	0.9922
230058	07/01/90	06/30/91	1.1375	0.9646	230232	07/01/90	06/30/91	1.0267	0.9643
230059	07/01/90	06/30/91	1.4107	0.9972					

Table 9 -- 1991 Transfer Adjusted Case Mix Index and Transfer
Adjustment to Discharges for Capital Hospital-Specific
Rate Redeterminations

Page 11 of 21

PROVIDER NUMBER	COST REPORTING PERIOD BEGIN - END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES	PROVIDER NUMBER	COST REPORTING PERIOD BEGIN - END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES
230241	04/01/90 - 03/31/91	1.1339	0.9860	260009	06/01/90 - 05/31/91	1.2422	0.9836
230264	07/01/90 - 06/30/91	1.3831	0.9895	260013	05/01/90 - 04/30/91	1.1233	0.9994
240002	07/01/90 - 06/30/91	1.6660	0.9943	260016	07/01/90 - 06/30/91	1.2100	0.9934
240005	07/01/90 - 06/30/91	0.9399	0.9040	260020	07/01/90 - 06/30/91	1.5593	0.9981
240009	07/01/90 - 06/30/91	1.0401	0.9659	260022	06/01/90 - 05/31/91	1.3887	0.9875
240017	05/01/90 - 04/30/91	1.2162	0.9733	260033	05/01/90 - 04/30/91	1.2920	0.9919
240036	07/01/90 - 06/30/91	1.4798	0.9974	260037	02/01/90 - 01/31/91	1.2101	0.9881
240037	07/01/90 - 06/30/91	1.0509	0.9973	260042	07/01/90 - 06/30/91	1.0944	0.9860
240040	07/01/90 - 06/30/91	1.2473	0.9582	260047	07/01/90 - 06/30/91	1.3049	0.9894
240044	05/01/90 - 04/30/91	1.1733	0.9730	260048	05/01/90 - 04/30/91	1.3596	0.9983
240049	07/01/90 - 06/30/91	1.6220	0.9971	260049	07/01/90 - 06/30/91	0.8563	0.9559
240075	07/01/90 - 06/30/91	1.2347	0.9826	260051	06/01/90 - 05/31/91	1.2717	0.9978
240077	07/01/90 - 06/30/91	0.9707	0.9583	260052	07/01/90 - 06/30/91	1.1541	0.9886
240089	04/01/90 - 03/31/91	1.0613	0.9887	260055	07/01/90 - 06/30/91	1.1939	0.9694
240090	05/01/90 - 04/30/91	1.0214	0.9738	260059	07/01/90 - 06/30/91	1.0585	0.9570
240099	06/01/90 - 05/31/91	0.9927	0.9873	260061	07/01/90 - 06/30/91	1.1293	0.9793
240101	07/01/90 - 06/30/91	1.1759	0.9692	260065	07/01/90 - 06/30/91	1.5749	0.9987
240104	07/01/90 - 06/30/91	1.2391	0.9819	260066	07/01/90 - 06/30/91	1.0481	0.9664
240110	07/01/90 - 06/30/91	1.0044	0.9621	260067	07/01/90 - 06/30/91	0.9562	0.9523
240125	06/01/90 - 05/31/91	0.9366	0.9807	260077	07/01/90 - 06/30/91	1.3796	0.9940
240129	06/01/90 - 05/31/91	0.9738	0.9657	260079	07/01/90 - 06/30/91	1.0012	0.9700
240137	04/01/90 - 03/31/91	1.2096	0.9726	260081	07/01/90 - 06/30/91	1.3967	0.9978
240145	03/01/90 - 02/28/91	0.9405	0.9625	260082	04/01/90 - 03/31/91	1.1584	0.9873
240158	05/01/90 - 04/30/91	0.9840	0.9255	260083	07/01/90 - 06/30/91	1.4306	0.9979
240160	07/01/90 - 06/30/91	0.9661	0.9779	260086	04/01/90 - 03/31/91	0.9677	0.9819
240167	01/01/90 - 01/12/91	0.8628	0.9311	260089	05/01/90 - 04/30/91	1.0935	0.9914
240171	05/01/90 - 04/30/91	1.1386	0.9557	260090	07/01/90 - 06/30/91	1.4546	0.9924
240175	06/01/90 - 05/31/91	0.8325	1.0000	260094	05/01/90 - 04/30/91	1.0405	0.9968
240176	07/01/90 - 06/30/91	0.9167	0.9851	260095	07/01/90 - 06/30/91	1.3605	0.9972
250001	07/01/90 - 06/30/91	1.4630	0.9956	260096	07/01/90 - 06/30/91	1.4352	0.9985
250006	07/01/90 - 06/30/91	0.9807	0.9855	260104	07/01/90 - 06/30/91	1.5896	0.9973
250016	05/01/90 - 04/30/91	0.8531	0.9958	260105	07/01/90 - 06/30/91	1.8521	0.9966
250017	04/01/90 - 03/31/91	0.9836	0.9700	260108	07/01/90 - 06/30/91	1.6264	0.9988
250031	05/01/90 - 04/30/91	1.2181	0.9909	260109	04/01/90 - 03/31/91	1.0410	0.9553
250032	07/01/90 - 06/30/91	1.1559	0.9908	260112	05/01/90 - 04/30/91	1.3629	0.9989
250033	04/01/90 - 03/31/91	1.0643	0.9546	260115	07/01/90 - 06/30/91	1.0573	0.9394
250034	07/01/90 - 06/30/91	1.4511	0.9938	260127	07/01/90 - 06/30/91	1.0865	0.9734
250044	07/01/90 - 06/30/91	1.0662	0.9809	260128	07/01/90 - 06/30/91	1.0149	0.9583
250046	04/01/90 - 03/31/91	1.0081	0.9614	260129	06/01/90 - 05/31/91	1.0830	0.9910
250094	04/01/90 - 03/31/91	1.2087	0.9968	260131	04/01/90 - 03/31/91	1.3070	0.9575
250102	07/01/90 - 06/30/91	1.3986	0.9990	260137	06/01/90 - 06/30/91	1.2395	1.0000
250123	03/01/90 - 02/28/91	1.1269	0.9902	260141	07/01/90 - 06/30/91	1.9490	0.9899
250126	04/01/90 - 03/31/91	0.9989	0.9572	260142	05/01/90 - 04/30/91	1.2315	0.9738
250128	05/01/90 - 04/30/91	0.9753	0.9570	260143	07/01/90 - 06/30/91	1.1842	0.9692
250134	07/01/90 - 06/30/91	0.9549	1.0000	260146	07/01/90 - 06/30/91	1.2012	0.9903
250138	05/01/90 - 04/30/91	1.2602	0.9912	260147	07/01/90 - 06/30/91	1.0283	0.9722
250141	07/01/90 - 06/30/91	1.1664	0.9854	260148	07/01/90 - 06/30/91	1.0108	0.9556
250143	12/14/89 - 01/02/91	0.9096	0.9822	260163	04/01/90 - 03/31/91	1.1921	0.9570
260001	07/01/90 - 06/30/91	1.5647	0.9991	260164	05/01/90 - 04/30/91	1.0989	0.9696
260002	06/01/90 - 05/31/91	1.3093	0.9876	260172	07/01/90 - 06/30/91	1.0282	0.9793
260006	07/01/90 - 06/30/91	1.3137	0.9910	260173	07/01/90 - 06/30/91	1.1111	0.8950
260007	04/01/90 - 03/31/91	1.1853	0.9941	260175	04/01/90 - 03/31/91	1.1710	0.9822
260008	07/01/90 - 06/30/91	1.2363	0.9933	260176	05/01/90 - 04/30/91	1.3154	0.9912

Table 9 -- 1991 Transfer Adjusted Case Mix Index and Transfer Adjustment to Discharges for Capital Hospital-Specific Rate Redeterminations

Page 12 of 21

PROVIDER NUMBER	COST REPORTING PERIOD BEGIN - END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES	PROVIDER NUMBER	COST REPORTING PERIOD BEGIN - END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES
260177	07/01/90 - 06/30/91	1.3056	0.9909	280024	07/01/90 - 06/30/91	0.8356	0.9608
260182	07/01/90 - 06/30/91	1.0392	0.9655	280026	07/01/90 - 06/30/91	1.0319	0.9812
260183	07/01/90 - 06/30/91	1.4172	0.9332	280028	05/01/90 - 04/30/91	0.8778	0.9576
260186	05/01/90 - 04/30/91	1.1376	0.9571	280029	07/01/90 - 06/30/91	0.9899	0.9620
260189	07/01/90 - 06/30/91	0.9479	0.9752	280033	07/01/90 - 06/30/91	0.9512	0.9930
260197	02/01/90 - 01/31/91	1.2524	0.9949	280035	07/01/90 - 06/30/91	0.9111	0.9373
260198	07/01/90 - 06/30/91	1.2822	0.9868	280037	07/01/90 - 06/30/91	0.9111	0.9475
270003	06/01/90 - 05/31/91	1.1879	0.9887	280042	05/01/90 - 04/30/91	1.0014	0.9778
270004	07/01/90 - 06/30/91	1.6946	0.9984	280043	07/01/90 - 06/30/91	1.1113	0.9684
270009	06/01/90 - 05/31/91	1.0669	0.9770	280045	07/01/90 - 06/30/91	1.1097	0.9958
270011	07/01/90 - 06/30/91	1.1355	0.9720	280049	05/01/90 - 04/30/91	1.0162	0.9837
270012	07/01/90 - 06/30/91	1.3808	0.9974	280050	07/01/90 - 06/30/91	0.9829	0.9640
270016	07/01/90 - 06/30/91	0.9477	0.9175	280051	07/01/90 - 06/30/91	1.0257	0.9984
270017	06/01/90 - 05/31/91	1.2210	0.9802	280052	07/01/90 - 06/30/91	1.0660	0.9757
270023	07/01/90 - 06/30/91	1.2716	0.9913	280055	07/01/90 - 06/30/91	0.9920	0.9408
270024	07/01/90 - 06/30/91	1.0515	0.9849	280056	07/01/90 - 06/30/91	1.0023	0.9789
270026	07/01/90 - 06/30/91	0.9600	0.9560	280060	07/01/90 - 06/30/91	1.4360	0.9988
270027	07/01/90 - 06/30/91	1.0052	0.9865	280062	07/01/90 - 06/30/91	1.1430	0.9664
270028	07/01/90 - 06/30/91	1.0193	0.9737	280064	05/01/90 - 04/30/91	1.0898	0.9708
270029	07/01/90 - 06/30/91	1.0603	0.9841	280066	07/01/90 - 06/30/91	1.1385	0.9911
270031	06/01/90 - 06/30/91	0.8856	0.9640	280068	04/01/90 - 03/31/91	0.8758	0.9128
270032	07/01/90 - 06/30/91	1.1106	0.9683	280070	05/01/90 - 04/30/91	0.9996	0.9276
270036	07/01/90 - 06/30/91	0.9661	0.9928	280073	07/01/90 - 06/30/91	1.0010	0.9461
270040	07/01/90 - 06/30/91	1.0172	0.9558	280075	07/01/90 - 06/30/91	1.3199	0.9813
270044	07/01/90 - 06/30/91	1.1592	0.9672	280077	07/01/90 - 06/30/91	1.2948	0.9820
270046	05/01/90 - 04/30/91	0.9527	0.9657	280078	05/01/90 - 04/30/91	0.9194	0.8852
270047	07/01/90 - 06/30/91	0.9262	0.9248	280080	07/01/90 - 06/30/91	1.0813	0.9689
270049	06/01/90 - 05/31/91	1.5876	0.9972	280082	03/01/90 - 02/28/91	1.2983	0.9888
270050	07/01/90 - 06/30/91	1.0346	0.9576	280084	07/01/90 - 06/30/91	0.9546	0.9518
270051	04/01/90 - 03/31/91	1.2089	0.9924	280090	07/01/90 - 06/30/91	0.9664	0.9719
270052	07/01/90 - 06/30/91	1.0396	0.9558	280091	07/01/90 - 06/30/91	1.0221	0.9801
270053	07/01/90 - 06/30/91	0.8383	0.8336	280092	07/01/90 - 06/30/91	0.9631	0.8984
270055	07/01/90 - 06/30/91	0.6368	0.9758	280094	04/01/90 - 03/31/91	1.0863	0.9748
270058	07/01/90 - 06/30/91	0.9847	0.9795	280097	07/01/90 - 06/30/91	0.9064	0.9276
270060	07/01/90 - 06/30/91	0.9500	0.9091	280098	07/01/90 - 06/30/91	0.9917	0.9911
270067	05/01/90 - 04/30/91	0.9493	0.9951	280104	07/01/90 - 06/30/91	0.9589	0.8916
270068	07/01/90 - 06/30/91	0.8888	0.8945	280105	07/01/90 - 06/30/91	1.2099	0.9909
270072	07/01/90 - 06/30/91	0.8672	0.9038	280110	07/01/90 - 06/30/91	1.0343	0.9660
270073	07/01/90 - 06/30/91	1.1772	0.9532	280111	05/01/90 - 04/30/91	1.2069	0.9830
270079	07/01/90 - 06/30/91	0.9509	0.9460	280117	07/01/90 - 06/30/91	1.0399	0.9702
270080	07/01/90 - 06/30/91	1.0930	0.9736	280118	07/01/90 - 06/30/91	0.9524	0.9000
270081	07/01/90 - 06/30/91	0.9303	0.9642	280123	07/01/90 - 06/30/91	0.9442	0.9702
270082	07/01/90 - 06/30/91	0.8880	0.9723	290001	07/01/90 - 06/30/91	1.5795	0.9999
280003	06/01/90 - 05/31/91	1.8344	0.9977	290002	04/01/90 - 03/31/91	0.9768	0.9271
280009	07/01/90 - 06/30/91	1.4787	0.9883	290007	07/01/90 - 06/30/91	1.6757	0.9972
280011	07/01/90 - 06/30/91	1.0097	0.9688	290008	07/01/90 - 06/30/91	1.2653	0.9688
280013	07/01/90 - 06/30/91	1.8270	0.9960	290011	07/01/90 - 06/30/91	1.0149	0.9647
280014	07/01/90 - 06/30/91	0.9956	0.9687	290012	07/01/90 - 06/30/91	1.3171	0.9843
280018	07/01/90 - 06/30/91	0.9430	0.9635	290013	07/01/90 - 06/30/91	1.0380	0.9808
280020	07/01/90 - 06/30/91	1.4431	0.9925	290014	07/01/90 - 06/30/91	0.9425	0.9344
280021	07/01/90 - 06/30/91	1.1404	0.9680	290015	07/01/90 - 06/30/91	0.9952	0.9179
280022	07/01/90 - 06/30/91	1.0412	0.9839	290016	07/01/90 - 06/30/91	1.0926	0.9511
280023	07/01/90 - 06/30/91	1.3730	0.9845	290019	07/01/90 - 06/30/91	1.1997	0.9825

Table 9 -- 1991 Transfer Adjusted Case Mix Index and Transfer
Adjustment to Discharges for Capital Hospital-Specific
Rate Redeterminations

PROVIDER NUMBER	COST REPORTING PERIOD BEGIN - END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES	PROVIDER NUMBER	COST REPORTING PERIOD BEGIN - END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES
290020	07/01/90 - 06/30/91	0.8756	0.9549	340030	07/01/90 - 06/30/91	1.7215	0.9974
290027	07/01/90 - 06/30/91	0.9515	0.9970	340032	07/01/90 - 06/30/91	1.2876	0.9882
300003	07/01/90 - 06/30/91	1.8397	0.9956	340047	07/01/90 - 06/30/91	1.7385	0.9983
300010	07/01/90 - 06/30/91	1.2596	0.9733	340061	07/01/90 - 06/30/91	1.5983	0.9987
300015	07/01/90 - 06/30/91	1.0261	0.9383	340073	07/01/90 - 06/30/91	1.3335	0.9946
300019	07/01/90 - 06/30/91	1.2401	0.9886	340076	07/01/90 - 06/30/91	1.0047	0.9731
300029	03/01/90 - 02/28/91	1.2481	0.9898	340116	05/01/90 - 04/30/91	1.6776	0.9940
300034	07/01/90 - 06/30/91	1.7137	0.9967	340135	07/01/90 - 06/30/91	1.1003	0.8391
310119	07/01/90 - 06/30/91	1.5159	0.9969	340136	07/01/90 - 06/30/91	0.9989	1.0000
320001	07/01/90 - 06/30/91	1.4283	0.9880	340137	07/01/90 - 06/30/91	1.3079	1.0000
320002	07/01/90 - 06/30/91	1.2533	0.9912	340138	07/01/90 - 06/30/91	1.0945	0.9856
320003	07/01/90 - 06/30/91	1.1558	0.9829	340143	07/01/90 - 06/30/91	1.3605	0.9882
320004	07/01/90 - 06/30/91	1.1740	0.9929	340144	03/01/90 - 02/28/91	1.2847	0.9961
320005	07/01/90 - 06/30/91	1.2622	0.9885	340148	07/01/90 - 06/30/91	1.3048	0.9947
320006	07/01/90 - 06/30/91	1.1903	0.9857	340153	03/01/90 - 02/28/91	1.9009	0.9993
320009	07/01/90 - 06/30/91	1.3160	0.9946	340154	07/01/90 - 06/30/91	0.9967	1.0000
320011	04/01/90 - 03/31/91	0.9783	0.9750	340155	07/01/90 - 06/30/91	1.5121	0.9972
320012	04/01/90 - 03/31/91	0.9280	0.9343	340158	07/01/90 - 06/30/91	1.0621	0.9917
320013	06/01/90 - 05/31/91	1.0896	0.9778	340160	07/01/90 - 06/30/91	1.0394	0.9591
320014	07/01/90 - 06/30/91	0.9685	0.9476	340164	06/01/90 - 05/31/91	1.3063	0.9922
320016	07/01/90 - 06/30/91	1.2000	0.9785	350001	07/01/90 - 06/30/91	1.1017	0.9931
320017	07/01/90 - 06/30/91	1.1867	0.9979	350002	07/01/90 - 06/30/91	1.6667	0.9985
320018	07/01/90 - 06/30/91	1.2056	0.9949	350003	07/01/90 - 06/30/91	1.1090	0.9772
320021	04/01/90 - 03/31/91	1.6351	0.9964	350005	07/01/90 - 06/30/91	1.1289	0.9522
320022	04/01/90 - 03/31/91	1.2168	0.9824	350006	07/01/90 - 06/30/91	1.3771	0.9932
320023	06/01/90 - 05/31/91	1.1190	0.9771	350008	07/01/90 - 06/30/91	1.0511	0.9683
320030	07/01/90 - 06/30/91	1.0400	0.9650	350009	07/01/90 - 06/30/91	1.1467	0.9794
320031	07/01/90 - 06/30/91	0.9575	0.9809	350010	04/01/90 - 03/31/91	1.0950	0.9885
320032	04/01/90 - 03/31/91	0.9144	0.9481	350011	07/01/90 - 06/30/91	1.7378	1.0000
320033	07/01/90 - 06/30/91	1.0408	0.9956	350012	07/01/90 - 06/30/91	1.0006	0.9902
320037	07/01/90 - 06/30/91	1.2383	0.9184	350013	07/01/90 - 06/30/91	1.0679	0.9722
320046	04/01/90 - 03/31/91	1.0655	0.9492	350014	07/01/90 - 06/30/91	1.0694	0.9852
320048	07/01/90 - 06/30/91	1.3045	0.9916	350016	07/01/90 - 06/30/91	1.2278	0.9712
320065	04/01/90 - 03/31/91	1.1809	0.9623	350017	07/01/90 - 06/30/91	1.0964	0.9752
320068	07/01/90 - 06/30/91	0.8598	0.9619	350021	07/01/90 - 06/30/91	1.0964	0.9659
320069	07/01/90 - 06/30/91	1.0743	0.9582	350025	07/01/90 - 06/30/91	0.9736	0.9659
320074	07/01/90 - 06/30/91	1.0522	0.9861	350029	07/01/90 - 06/30/91	0.9546	0.9402
320076	04/01/90 - 03/31/91	1.1648	0.9832	350030	07/01/90 - 06/30/91	1.0611	0.9853
320079	04/01/90 - 03/31/91	1.0681	0.9879	350031	07/01/90 - 06/30/91	0.9771	0.9703
330127	07/01/90 - 06/30/91	1.2402	0.9940	350032	07/01/90 - 06/30/91	1.1451	1.0000
330128	07/01/90 - 06/30/91	1.2268	0.9616	350034	07/01/90 - 06/30/91	0.9603	0.9841
330196	07/01/90 - 06/30/91	1.3881	0.9946	350035	07/01/90 - 06/30/91	0.8435	0.9283
330199	07/01/90 - 06/30/91	1.3913	0.9991	350036	07/01/90 - 06/30/91	0.8991	0.8986
330202	07/01/90 - 06/30/91	1.2429	0.9962	350038	07/01/90 - 06/30/91	0.9377	0.9762
330204	07/01/90 - 06/30/91	1.2290	0.9839	350039	07/01/90 - 06/30/91	0.8850	0.9466
330231	07/01/90 - 06/30/91	1.2010	0.9970	350043	07/01/90 - 06/30/91	1.4861	0.9964
330240	07/01/90 - 06/30/91	1.3066	0.9974	350044	07/01/90 - 06/30/91	0.8672	0.9920
330354	04/01/90 - 03/31/91	1.1394	1.0000	350047	07/01/90 - 06/30/91	1.1156	0.9397
330385	07/01/90 - 06/30/91	1.1988	0.9835	350049	07/01/90 - 06/30/91	1.0699	0.9722
340014	07/01/90 - 06/30/91	1.6111	0.9993	350053	07/01/90 - 06/30/91	0.8745	0.9809
340019	07/01/90 - 06/30/91	1.0695	0.9907	350056	04/01/90 - 03/31/91	1.0174	0.9705
340020	06/01/90 - 05/31/91	1.2379	0.9709	350060	07/01/90 - 06/30/91	0.9915	1.0000

Table 9 -- 1991 Transfer Adjusted Case Mix Index and Transfer Adjustment to Discharges for Capital Hospital-Specific Rate Redeterminations

Page 14 of 21

PROVIDER NUMBER	COST REPORTING PERIOD BEGIN - END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES	PROVIDER NUMBER	COST REPORTING PERIOD BEGIN - END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES
350061	04/01/90 - 03/31/91	1.0214	0.9897	370059	07/01/90 - 06/30/91	1.2710	0.9852
350065	03/01/90 - 02/28/91	0.9734	0.9403	370060	06/01/90 - 05/31/91	0.9757	0.9510
350067	07/01/90 - 06/30/91	0.9935	0.9174	370063	07/01/90 - 06/30/91	1.1823	0.9717
360003	07/01/90 - 06/30/91	1.5017	0.9953	370064	05/01/90 - 04/30/91	0.9092	0.9389
360006	07/01/90 - 06/30/91	1.6791	0.9984	370065	07/01/90 - 06/30/91	1.1184	0.9501
360008	07/01/90 - 06/30/91	1.1948	0.9776	370069	07/01/90 - 06/30/91	1.0008	0.9670
360011	07/01/90 - 06/30/91	1.2533	0.9931	370071	07/01/90 - 06/30/91	0.9890	0.9582
360014	07/01/90 - 06/30/91	1.1771	0.9728	370072	07/01/90 - 06/30/91	0.9622	0.9644
360017	07/01/90 - 06/30/91	1.7318	0.9966	370076	07/01/90 - 06/30/91	1.0812	0.9903
360028	07/01/90 - 06/30/91	1.3095	0.9890	370079	07/01/90 - 06/30/91	0.9241	0.9668
360029	07/01/90 - 06/30/91	1.1000	0.9868	370080	07/01/90 - 06/30/91	0.9558	0.9580
360035	06/01/90 - 05/31/91	1.4449	0.9978	370082	07/01/90 - 06/30/91	1.0274	0.9390
360040	07/01/90 - 06/30/91	1.2708	0.9656	370083	04/01/90 - 03/31/91	1.0243	0.9776
360048	07/01/90 - 06/30/91	1.6749	0.9963	370084	07/01/90 - 06/30/91	0.8456	0.9411
360052	07/01/90 - 06/30/91	1.5723	0.9990	370085	04/01/90 - 03/31/91	0.8678	0.9601
360054	07/01/90 - 06/30/91	1.3044	0.9831	370086	07/01/90 - 06/30/91	1.0629	0.9793
360058	07/01/90 - 06/30/91	1.0752	0.9752	370089	07/01/90 - 06/30/91	1.2536	0.9793
360090	07/01/90 - 06/30/91	1.6396	0.9901	370091	07/01/90 - 06/30/91	1.5052	0.9991
360134	07/01/90 - 06/30/91	1.1621	0.9946	370097	04/01/90 - 03/31/91	1.2682	0.9979
360136	07/01/90 - 06/30/91	1.5056	0.9994	370099	07/01/90 - 06/30/91	1.1150	0.9727
360161	07/01/90 - 06/30/91	1.2345	0.9842	370100	07/01/90 - 06/30/91	1.0240	0.9635
360178	07/01/90 - 06/30/91	1.1999	0.9882	370103	07/01/90 - 06/30/91	0.9162	0.9425
360185	07/01/90 - 06/30/91	1.1791	0.9884	370110	07/01/90 - 06/30/91	0.9846	0.9616
360187	07/01/90 - 06/30/91	1.3453	0.9876	370112	04/01/90 - 03/31/91	0.8393	0.9443
360238	07/01/90 - 06/30/91	0.8813	0.9824	370113	07/01/90 - 06/30/91	1.0989	0.9845
370004	07/01/90 - 06/30/91	1.1375	0.9758	370122	04/01/90 - 03/31/91	0.8986	0.9506
370005	07/01/90 - 06/30/91	0.9539	0.9649	370123	07/01/90 - 06/30/91	1.1332	0.9947
370008	07/01/90 - 06/30/91	1.1991	0.9933	370125	07/01/90 - 06/30/91	0.9880	0.9794
370011	07/01/90 - 06/30/91	0.9422	0.9775	370126	07/01/90 - 06/30/91	1.1067	0.9697
370012	07/01/90 - 06/30/91	0.8948	0.9441	370131	05/01/90 - 04/30/91	1.0051	0.9419
370013	07/01/90 - 06/30/91	1.3686	0.9990	370133	07/01/90 - 06/30/91	1.1834	0.9189
370015	07/01/90 - 06/30/91	1.1192	0.9757	370138	07/01/90 - 06/30/91	1.1626	0.9662
370016	07/01/90 - 06/30/91	1.2813	0.9964	370139	07/01/90 - 06/30/91	0.9940	0.9724
370019	07/01/90 - 06/30/91	1.1148	0.9691	370140	07/01/90 - 06/30/91	1.0402	0.9728
370022	07/01/90 - 06/30/91	1.3322	0.9800	370153	07/01/90 - 06/30/91	1.0965	0.9805
370023	07/01/90 - 06/30/91	1.2936	0.9829	370154	07/01/90 - 06/30/91	1.0265	0.9540
370026	07/01/90 - 06/30/91	1.3037	0.9965	370156	07/01/90 - 06/30/91	0.9972	0.9416
370028	07/01/90 - 06/30/91	1.5874	0.9989	370158	07/01/90 - 06/30/91	1.0318	0.9546
370029	07/01/90 - 06/30/91	1.2024	0.9429	370159	07/01/90 - 06/30/91	1.1554	0.9812
370030	07/01/90 - 06/30/91	1.2150	0.9719	370163	07/01/90 - 06/30/91	0.8709	0.9661
370034	07/01/90 - 06/30/91	1.1186	0.9837	370166	02/01/90 - 01/31/91	1.1121	0.9667
370035	07/01/90 - 06/30/91	1.4775	0.9949	370178	07/01/90 - 06/30/91	0.9784	0.9761
370036	07/01/90 - 06/30/91	1.0831	0.9331	370183	07/01/90 - 06/30/91	1.1021	0.9506
370041	07/01/90 - 06/30/91	1.0349	0.9484	370186	07/01/90 - 06/30/91	0.9547	0.9510
370042	07/01/90 - 06/30/91	1.0025	0.9646	380001	07/01/90 - 06/30/91	1.3388	0.9877
370043	07/01/90 - 06/30/91	0.8910	0.9737	380002	07/01/90 - 06/30/91	1.1999	0.9774
370045	07/01/90 - 06/30/91	0.9592	0.9718	380003	07/01/90 - 06/30/91	1.1124	0.9869
370046	07/01/90 - 06/30/91	1.0777	0.9627	380005	07/01/90 - 06/30/91	1.2009	0.9831
370047	07/01/90 - 06/30/91	1.0141	0.9481	380007	04/01/90 - 03/31/91	1.7272	0.9942
370048	07/01/90 - 06/30/91	1.2306	0.9918	380008	04/01/90 - 03/31/91	1.0688	0.9759
370050	07/01/90 - 06/30/91	1.2252	0.9470	380009	07/01/90 - 06/30/91	1.6095	0.9968
370056	07/01/90 - 06/30/91	0.8390	0.9106	380011	07/01/90 - 06/30/91	1.1564	0.9776
		1.4442	0.9954	380013	07/01/90 - 06/30/91	1.2606	0.9547

Table 9 -- 1991 Transfer Adjusted Case Mix Index and Transfer
Adjustment to Discharges for Capital Hospital-Specific
Rate Redeterminations

Page 15 of 21

PROVIDER NUMBER	COST REPORTING PERIOD BEGIN - END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES	PROVIDER NUMBER	COST REPORTING PERIOD BEGIN - END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES
380017	04/01/90 - 03/31/91	1.7207	0.9975	390027	07/01/90 - 06/30/91	1.6723	0.9966
380023	07/01/90 - 06/30/91	1.3293	0.9613	390028	07/01/90 - 06/30/91	1.6719	0.9986
380024	04/01/90 - 03/31/91	1.2888	0.9895	390029	07/01/90 - 06/30/91	1.6217	0.9980
380025	04/01/90 - 03/31/91	1.2479	0.9803	390030	07/01/90 - 06/30/91	1.1465	0.9946
380027	07/01/90 - 06/30/91	1.2178	0.9871	390031	07/01/90 - 06/30/91	1.1501	0.9865
380031	07/01/90 - 06/30/91	1.0158	0.9858	390032	07/01/90 - 06/30/91	1.1989	0.9923
380033	07/01/90 - 06/30/91	1.6581	0.9984	390033	07/01/90 - 06/30/91	1.2909	0.9913
380035	05/01/90 - 04/30/91	1.2283	0.9764	390036	07/01/90 - 06/30/91	1.2175	0.9935
380037	07/01/90 - 06/30/91	1.2306	0.9592	390037	07/01/90 - 06/30/91	1.2158	0.9877
380040	07/01/90 - 06/30/91	1.3621	0.9767	390039	07/01/90 - 06/30/91	1.0524	0.9835
380048	07/01/90 - 06/30/91	1.0095	0.9459	390040	07/01/90 - 06/30/91	0.9540	0.9901
380059	07/01/90 - 06/30/91	0.9255	0.9835	390041	07/01/90 - 06/30/91	1.2272	0.9825
380062	07/01/90 - 06/30/91	0.9483	0.9722	390042	07/01/90 - 06/30/91	1.2386	0.9899
380063	07/01/90 - 06/30/91	1.2571	0.9888	390043	07/01/90 - 06/30/91	1.0626	0.9860
380065	07/01/90 - 06/30/91	1.0684	0.9663	390044	07/01/90 - 06/30/91	1.5211	0.9983
380066	07/01/90 - 06/30/91	1.0904	0.9717	390045	07/01/90 - 06/30/91	1.2884	0.9911
380069	07/01/90 - 06/30/91	1.1161	0.9897	390046	07/01/90 - 06/30/91	1.4060	0.9984
380071	05/01/90 - 04/30/91	1.2359	0.9755	390047	07/01/90 - 06/30/91	1.4703	0.9955
380072	07/01/90 - 06/30/91	0.9356	0.9270	390048	07/01/90 - 06/30/91	1.1171	0.9863
380078	07/01/90 - 06/30/91	1.1513	0.9661	390049	07/01/90 - 06/30/91	1.5110	0.9978
380081	07/01/90 - 06/30/91	1.0650	0.9604	390050	07/01/90 - 06/30/91	1.8470	0.9983
380083	07/01/90 - 06/30/91	1.1666	0.9679	390051	07/01/90 - 06/30/91	2.0545	0.9978
380084	05/01/90 - 04/30/91	1.2897	0.9792	390052	07/01/90 - 06/30/91	1.1390	0.9769
380087	07/01/90 - 06/30/91	0.9536	0.9547	390053	07/01/90 - 06/30/91	1.6520	0.9989
380088	07/01/90 - 06/30/91	0.9528	0.9860	390056	07/01/90 - 06/30/91	1.1049	0.9877
380089	04/01/90 - 03/31/91	1.3093	0.9788	390057	07/01/90 - 06/30/91	1.2691	0.9956
380090	07/01/90 - 06/30/91	1.3438	0.9832	390058	07/01/90 - 06/30/91	1.3167	0.9858
380094	07/01/90 - 06/30/91	1.1364	0.9947	390059	07/01/90 - 06/30/91	1.3048	0.9952
390001	07/01/90 - 06/30/91	1.2097	0.9933	390061	07/01/90 - 06/30/91	1.2385	0.9888
390002	07/01/90 - 06/30/91	1.1911	0.9965	390062	07/01/90 - 06/30/91	1.1852	0.9851
390003	07/01/90 - 06/30/91	1.1548	0.9924	390063	07/01/90 - 06/30/91	1.5982	0.9989
390004	07/01/90 - 06/30/91	1.2504	0.9990	390064	07/01/90 - 06/30/91	1.3726	0.9982
390005	07/01/90 - 06/30/91	1.0984	0.9909	390065	07/01/90 - 06/30/91	1.2253	0.9833
390006	07/01/90 - 06/30/91	1.6355	0.9990	390066	07/01/90 - 06/30/91	1.2884	0.9859
390007	07/01/90 - 06/30/91	1.1969	0.9904	390067	07/01/90 - 06/30/91	1.4798	0.9985
390008	07/01/90 - 06/30/91	1.1199	0.9697	390068	07/01/90 - 06/30/91	1.2652	0.9898
390009	07/01/90 - 06/30/91	1.4935	0.9991	390069	07/01/90 - 06/30/91	1.2673	0.9904
390010	07/01/90 - 06/30/91	1.1311	0.9868	390070	07/01/90 - 06/30/91	1.1561	0.9898
390011	07/01/90 - 06/30/91	1.1900	0.9926	390071	07/01/90 - 06/30/91	1.1042	0.9911
390012	07/01/90 - 06/30/91	1.2037	0.9876	390072	07/01/90 - 06/30/91	0.9840	0.9862
390013	07/01/90 - 06/30/91	1.1676	0.9888	390073	07/01/90 - 06/30/91	1.4683	0.9984
390014	07/01/90 - 06/30/91	0.7687	1.0000	390074	07/01/90 - 06/30/91	1.2184	0.9896
390015	07/01/90 - 06/30/91	1.1115	0.9722	390075	07/01/90 - 06/30/91	1.2866	0.9925
390016	07/01/90 - 06/30/91	1.1653	0.9885	390076	07/01/90 - 06/30/91	1.2191	0.9870
390017	07/01/90 - 06/30/91	1.1621	0.9893	390078	07/01/90 - 06/30/91	1.0701	0.9824
390018	07/01/90 - 06/30/91	1.2418	0.9931	390079	07/01/90 - 06/30/91	1.6409	0.9986
390019	07/01/90 - 06/30/91	1.1172	0.9747	390080	07/01/90 - 06/30/91	1.1679	0.9934
390021	07/01/90 - 06/30/91	1.0388	0.9848	390081	07/01/90 - 06/30/91	1.2333	0.9934
390022	07/01/90 - 06/30/91	1.2521	0.9903	390083	07/01/90 - 06/30/91	1.1362	0.9932
390023	07/01/90 - 06/30/91	1.2248	0.9980	390084	07/01/90 - 06/30/91	1.1530	0.9954
390024	07/01/90 - 06/30/91	0.7829	0.9971	390086	07/01/90 - 06/30/91	1.0781	0.9722
390025	07/01/90 - 06/30/91	0.7981	0.9953	390088	07/01/90 - 06/30/91	1.3481	0.9927
390026	07/01/90 - 06/30/91	1.2649	0.9883	390090	07/01/90 - 06/30/91	1.7695	0.9979

Table 9 -- 1991 Transfer Adjusted Case Mix Index and Transfer Adjustment to Discharges for Capital Hospital-Specific Rate Redeterminations

Page 16 of 21

PROVIDER NUMBER	COST REPORTING PERIOD BEGIN	COST REPORTING PERIOD END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES	PROVIDER NUMBER	COST REPORTING PERIOD BEGIN	COST REPORTING PERIOD END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES
390091	07/01/90	06/30/91	1.1114	0.9935	390154	07/01/90	06/30/91	1.1099	0.9731
390092	07/01/90	06/30/91	1.1872	0.9891	390155	07/01/90	06/30/91	1.2475	0.9924
390093	07/01/90	06/30/91	1.1890	0.9916	390156	07/01/90	06/30/91	1.3673	0.9964
390095	07/01/90	06/30/91	1.2294	0.9896	390157	07/01/90	06/30/91	1.1958	0.9934
390096	07/01/90	06/30/91	1.2246	0.9924	390158	07/01/90	06/30/91	1.2307	0.9894
390097	07/01/90	06/30/91	1.3262	0.9842	390159	07/01/90	06/30/91	1.2797	0.9907
390098	07/01/90	06/30/91	1.5682	0.9979	390160	07/01/90	06/30/91	1.1852	0.9929
390100	07/01/90	06/30/91	1.1719	0.9983	390161	07/01/90	06/30/91	1.0620	0.9802
390101	07/01/90	06/30/91	1.2134	0.9939	390162	07/01/90	06/30/91	1.2345	0.9969
390102	07/01/90	06/30/91	1.2887	0.9967	390163	07/01/90	06/30/91	1.1909	0.9923
390103	07/01/90	06/30/91	1.0808	0.9906	390164	07/01/90	06/30/91	1.7807	0.9980
390104	07/01/90	06/30/91	1.0627	0.9685	390165	07/01/90	06/30/91	1.0931	0.9884
390106	07/01/90	06/30/91	1.0623	0.9785	390166	07/01/90	06/30/91	1.1164	0.9744
390107	07/01/90	06/30/91	1.1711	0.9952	390167	07/01/90	06/30/91	1.2352	0.9939
390108	07/01/90	06/30/91	1.3343	0.9910	390168	07/01/90	06/30/91	1.1815	0.9892
390109	07/01/90	06/30/91	1.1987	0.9886	390170	07/01/90	06/30/91	1.5875	0.9986
390110	07/01/90	06/30/91	1.2844	0.9923	390171	07/01/90	06/30/91	1.0941	0.9870
390111	07/01/90	06/30/91	1.7078	0.9966	390172	07/01/90	06/30/91	1.1852	0.9946
390112	07/01/90	06/30/91	1.1809	0.9778	390173	07/01/90	06/30/91	1.1193	0.9763
390113	07/01/90	06/30/91	1.2335	0.9905	390174	07/01/90	06/30/91	1.5378	0.9986
390114	07/01/90	06/30/91	1.0237	0.9979	390176	07/01/90	06/30/91	1.3225	0.9916
390115	07/01/90	06/30/91	1.2915	0.9874	390178	07/01/90	06/30/91	1.2185	0.9908
390116	07/01/90	06/30/91	1.1828	0.9856	390179	07/01/90	06/30/91	1.2383	0.9932
390117	07/01/90	06/30/91	1.1615	0.9783	390180	07/01/90	06/30/91	1.3587	0.9928
390118	07/01/90	06/30/91	1.1204	0.9865	390181	07/01/90	06/30/91	1.0826	0.9869
390119	07/01/90	06/30/91	1.3285	0.9970	390183	07/01/90	06/30/91	1.1504	0.9784
390121	07/01/90	06/30/91	1.2100	0.9956	390184	07/01/90	06/30/91	1.1175	0.9853
390122	07/01/90	06/30/91	1.0753	0.9825	390185	07/01/90	06/30/91	1.1687	0.9796
390123	07/01/90	06/30/91	1.2029	0.9882	390186	07/01/90	06/30/91	1.0656	0.9770
390125	07/01/90	06/30/91	1.2071	0.9947	390187	07/01/90	06/30/91	1.1208	0.9800
390126	07/01/90	06/30/91	1.2074	0.9897	390189	07/01/90	06/30/91	1.1301	0.9800
390127	07/01/90	06/30/91	1.0962	0.9885	390191	07/01/90	06/30/91	1.0757	0.9837
390128	07/01/90	06/30/91	1.1927	0.9897	390192	07/01/90	06/30/91	1.0850	0.9937
390130	07/01/90	06/30/91	1.0649	0.9547	390193	07/01/90	06/30/91	1.1960	0.9825
390131	07/01/90	06/30/91	1.2088	0.9958	390194	07/01/90	06/30/91	1.0956	0.9825
390132	07/01/90	06/30/91	1.1752	0.9911	390195	07/01/90	06/30/91	1.5382	0.9991
390133	07/01/90	06/30/91	1.3936	0.9944	390196	07/01/90	06/30/91	1.2794	0.9992
390135	07/01/90	06/30/91	1.2328	0.9943	390197	07/01/90	06/30/91	1.2889	0.9963
390136	07/01/90	06/30/91	1.1903	0.9968	390198	07/01/90	06/30/91	1.2604	0.9940
390137	07/01/90	06/30/91	1.1600	0.9970	390199	07/01/90	06/30/91	1.2407	0.9683
390138	07/01/90	06/30/91	1.2514	0.9824	390200	07/01/90	06/30/91	1.0501	0.9673
390139	07/01/90	06/30/91	1.4305	0.9987	390201	07/01/90	06/30/91	1.2932	0.9876
390142	07/01/90	06/30/91	1.6931	0.9997	390203	07/01/90	06/30/91	1.2768	0.9901
390143	07/01/90	06/30/91	0.9115	0.9997	390204	07/01/90	06/30/91	1.2898	0.9939
390145	07/01/90	06/30/91	1.2080	0.9860	390205	07/01/90	06/30/91	1.2393	0.9904
390146	07/01/90	06/30/91	1.1824	0.9828	390206	07/01/90	06/30/91	1.2576	0.9970
390147	07/01/90	06/30/91	1.1805	0.9934	390209	07/01/90	06/30/91	0.9776	0.9677
390148	07/01/90	06/30/91	1.1517	0.9994	390211	07/01/90	06/30/91	1.1444	0.9872
390149	07/01/90	06/30/91	1.2262	0.9889	390213	07/01/90	06/30/91	0.9783	0.9978
390150	07/01/90	06/30/91	1.2042	0.9814	390215	07/01/90	06/30/91	1.1795	0.9878
390151	07/01/90	06/30/91	1.2526	0.9941	390217	07/01/90	06/30/91	1.1297	0.9890
390152	07/01/90	06/30/91	0.9936	0.9897	390219	07/01/90	06/30/91	1.1992	0.9745
390153	07/01/90	06/30/91	1.1944	0.9898	390220	07/01/90	06/30/91	1.1300	0.9874

Table 9 -- 1991 Transfer Adjusted Case Mix Index and Transfer
Adjustment to Discharges for Capital Hospital-Specific
Rate Redeterminations

PROVIDER NUMBER	COST REPORTING PERIOD BEGIN - END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES	PROVIDER NUMBER	COST REPORTING PERIOD BEGIN - END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES
390222	07/01/90 - 06/30/91	1.2141	0.9921	400088	05/01/90 - 04/30/91	0.7940	0.9937
390223	07/01/90 - 06/30/91	1.5440	0.9963	400102	07/01/90 - 06/30/91	1.0980	0.9987
390225	07/01/90 - 06/30/91	1.2638	0.9813	400103	07/01/90 - 06/30/91	1.4353	0.9968
390226	07/01/90 - 06/30/91	1.5905	0.9988	400104	07/01/90 - 06/30/91	1.2608	0.9976
390228	07/01/90 - 06/30/91	1.1899	0.9946	400105	07/01/90 - 06/30/91	1.2810	0.9977
390229	07/01/90 - 06/30/91	1.4208	0.9966	400110	07/01/90 - 06/30/91	1.1678	0.9889
390231	07/01/90 - 06/30/91	1.3050	0.9949	400114	07/01/90 - 06/30/91	1.0679	0.9983
390232	07/01/90 - 06/30/91	1.0673	0.9762	420002	05/01/90 - 04/30/91	1.2944	0.9897
390233	07/01/90 - 06/30/91	1.2736	0.9946	420004	07/01/90 - 06/30/91	1.9072	0.9978
390235	07/01/90 - 06/30/91	1.7961	0.9966	420006	07/01/90 - 06/30/91	1.4690	0.9754
390236	07/01/90 - 06/30/91	1.2007	0.9908	420035	07/01/90 - 06/30/91	0.8228	0.9734
390238	07/01/90 - 06/30/91	0.9871	0.9912	420053	07/01/90 - 06/30/91	1.0876	0.9708
390242	07/01/90 - 06/30/91	1.2275	0.9925	420062	03/01/90 - 02/28/91	1.1626	0.9478
390244	07/01/90 - 06/30/91	0.8597	0.9516	420079	04/01/90 - 03/31/91	1.5274	0.9994
390245	07/01/90 - 06/30/91	1.3470	0.9912	420080	07/01/90 - 06/30/91	1.1316	0.9833
390246	07/01/90 - 06/30/91	1.2248	0.9843	420082	03/01/90 - 02/28/91	1.3316	0.9932
390247	07/01/90 - 06/30/91	1.0993	1.0000	420083	07/01/90 - 06/30/91	1.1658	0.9893
390249	04/01/90 - 03/31/91	0.9896	0.9791	420084	07/01/90 - 06/30/91	0.7915	0.9858
390252	07/01/90 - 06/30/91	0.6968	0.9911	420085	05/01/90 - 04/30/91	1.2280	0.9690
390256	07/01/90 - 06/30/91	1.5971	1.0000	430004	03/01/90 - 02/28/91	1.1402	0.9662
390258	07/01/90 - 06/30/91	1.2989	0.9895	430005	06/01/90 - 05/31/91	1.3185	0.9783
390260	07/01/90 - 06/30/91	1.2344	0.9884	430007	07/01/90 - 06/30/91	1.1639	0.9496
390261	07/01/90 - 06/30/91	1.7899	0.9967	430010	07/01/90 - 06/30/91	1.0791	0.9669
390262	07/01/90 - 06/30/91	1.6652	0.9951	430011	07/01/90 - 06/30/91	1.3043	0.9736
390263	07/01/90 - 06/30/91	1.4484	0.9897	430012	07/01/90 - 06/30/91	1.3139	0.9819
390265	07/01/90 - 06/30/91	1.2533	0.9937	430018	07/01/90 - 06/30/91	0.9506	0.9477
390266	07/01/90 - 06/30/91	1.1276	0.9816	430022	03/01/90 - 02/28/91	0.9585	0.9653
390267	07/01/90 - 06/30/91	1.2248	0.9921	430025	03/01/90 - 02/28/91	0.9697	0.9850
390268	07/01/90 - 06/30/91	1.2240	0.9910	430027	05/01/90 - 04/30/91	1.6450	0.9983
390270	07/01/90 - 06/30/91	1.2906	0.9898	430033	07/01/90 - 06/30/91	1.0076	0.9804
390275	07/01/90 - 06/30/91	0.5649	1.0000	430037	07/01/90 - 06/30/91	0.9559	0.9623
390277	07/01/90 - 06/30/91	1.7555	0.9714	430039	06/01/90 - 05/31/91	1.0101	0.9579
390278	07/01/90 - 06/30/91	0.9309	0.9552	430042	02/01/90 - 01/31/91	0.9559	0.9559
400001	07/01/90 - 06/30/91	1.1779	1.0000	430054	07/01/90 - 06/30/91	0.9351	0.9704
400003	07/01/90 - 06/30/91	1.1181	0.9978	430062	06/01/90 - 05/31/91	0.8614	0.9715
400004	07/01/90 - 06/30/91	1.1114	0.9997	430066	07/01/90 - 06/30/91	1.0587	0.9828
400006	07/01/90 - 06/30/91	1.1534	1.0000	430077	07/01/90 - 06/30/91	1.4025	0.9982
400009	07/01/90 - 06/30/91	0.9782	0.9995	440001	07/01/90 - 06/30/91	0.9762	0.9743
400012	07/01/90 - 06/30/91	1.0365	1.0000	440002	07/01/90 - 06/30/91	1.5374	0.9983
400013	04/01/90 - 03/31/91	0.9533	0.9868	440003	06/01/90 - 05/31/91	1.1209	0.9798
400015	07/01/90 - 06/30/91	1.0859	0.9984	440006	07/01/90 - 06/30/91	1.3686	0.9984
400018	04/01/90 - 03/31/91	1.2573	0.9963	440007	07/01/90 - 06/30/91	1.0311	0.9814
400021	06/01/90 - 05/31/91	1.2920	0.9995	440009	07/01/90 - 06/30/91	1.0392	0.9769
400026	07/01/90 - 06/30/91	0.9438	0.9843	440010	07/01/90 - 06/30/91	0.9363	0.9594
400028	07/01/90 - 06/30/91	1.0016	1.0000	440011	07/01/90 - 06/30/91	1.2235	0.9867
400029	07/01/90 - 06/30/91	1.0192	0.9974	440012	07/01/90 - 06/30/91	1.3204	0.9977
400037	07/01/90 - 06/30/91	0.7007	1.0000	440014	07/01/90 - 06/30/91	0.8939	0.9949
400038	07/01/90 - 06/30/91	0.8530	0.8693	440015	07/01/90 - 06/30/91	1.4676	0.9986
400044	07/01/90 - 06/30/91	1.2211	0.9945	440016	07/01/90 - 06/30/91	0.9608	0.9830
400048	07/01/90 - 06/30/91	1.1380	0.9933	440017	07/01/90 - 06/30/91	1.4413	0.9978
400061	07/01/90 - 06/30/91	1.7356	0.9981	440019	07/01/90 - 06/30/91	1.4770	0.9987
400079	07/01/90 - 06/30/91	1.1456	0.9906	440022	07/01/90 - 06/30/91	1.0793	0.9710
400087	03/01/90 - 02/28/91	1.2197	0.9958	440023	07/01/90 - 06/30/91	0.9704	0.9772

Table 9 -- 1991 Transfer Adjusted Case Mix Index and Transfer
Adjustment to Discharges for Capital Hospital-Specific
Rate Redeterminations

PROVIDER NUMBER	COST REPORTING PERIOD BEGIN - END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES	PROVIDER NUMBER	COST REPORTING PERIOD BEGIN - END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES
440024	07/01/90 - 06/30/91	1.1161	0.9874	440160	07/01/90 - 06/30/91	1.0415	0.9941
440025	07/01/90 - 06/30/91	1.1126	0.9969	440162	02/01/90 - 01/31/91	1.0256	0.9825
440029	07/01/90 - 06/30/91	1.2159	0.9900	440166	07/01/90 - 06/30/91	1.2564	0.9916
440030	07/01/90 - 06/30/91	1.0423	0.9686	440170	06/01/90 - 05/31/91	1.3581	0.9850
440031	07/01/90 - 06/30/91	1.0571	0.9691	440175	03/01/90 - 02/28/91	1.1497	0.9588
440032	07/01/90 - 06/30/91	0.9441	0.9775	440176	03/01/90 - 02/28/91	1.2108	0.9966
440033	07/01/90 - 06/30/91	1.0930	0.9630	440180	07/01/90 - 06/30/91	1.0816	0.9572
440035	07/01/90 - 06/30/91	1.1827	0.9803	440183	03/01/90 - 02/28/91	1.4033	0.9981
440038	07/01/90 - 06/30/91	0.9278	0.9810	440187	06/01/90 - 05/31/91	1.0669	0.9765
440039	07/01/90 - 06/30/91	1.5872	0.9957	440192	05/01/90 - 04/30/91	0.9524	0.9520
440040	07/01/90 - 06/30/91	0.8914	0.9545	440193	06/01/90 - 05/31/91	1.1061	0.9838
440051	07/01/90 - 06/30/91	0.9225	0.9816	440197	06/01/90 - 05/31/91	1.2922	0.9883
440052	07/01/90 - 06/30/91	1.1395	0.9635	450004	07/01/90 - 06/30/91	1.0749	0.9797
440053	07/01/90 - 06/30/91	1.1711	0.9860	450007	07/01/90 - 06/30/91	1.3505	0.9810
440054	07/01/90 - 06/30/91	0.9843	0.9787	450008	04/01/90 - 03/31/91	1.2471	0.9928
440056	07/01/90 - 06/30/91	0.9636	0.9752	450021	07/01/90 - 06/30/91	1.7150	0.9986
440057	07/01/90 - 06/30/91	0.9707	0.9735	450023	07/01/90 - 06/30/91	1.4203	0.9977
440059	07/01/90 - 06/30/91	1.1127	0.9758	450027	05/01/90 - 04/30/91	1.1610	0.9978
440060	07/01/90 - 06/30/91	1.1625	0.9757	450029	07/01/90 - 06/30/91	1.3613	0.9949
440063	07/01/90 - 06/30/91	1.4019	0.9985	450031	04/01/90 - 03/31/91	1.1709	0.9843
440065	07/01/90 - 06/30/91	1.0822	0.9700	450034	07/01/90 - 06/30/91	1.4837	0.9969
440069	07/01/90 - 06/30/91	1.1234	0.9916	450035	07/01/90 - 06/30/91	1.4810	0.9983
440070	07/01/90 - 06/30/91	0.9231	0.9444	450040	07/01/90 - 06/30/91	1.6102	0.9995
440073	07/01/90 - 06/30/91	1.2915	0.9853	450042	07/01/90 - 06/30/91	1.6372	0.9991
440074	07/01/90 - 06/30/91	0.8812	0.9676	450044	07/01/90 - 06/30/91	1.4597	0.9991
440082	07/01/90 - 06/30/91	1.8119	0.9986	450051	07/01/90 - 06/30/91	1.6535	0.9986
440084	07/01/90 - 06/30/91	1.0679	0.9765	450052	07/01/90 - 06/30/91	1.0361	0.9876
440090	07/01/90 - 06/30/91	1.0384	0.9652	450056	07/01/90 - 06/30/91	1.5902	0.9994
440102	07/01/90 - 06/30/91	1.0594	0.9790	450060	07/01/90 - 06/30/91	1.2988	0.9880
440103	07/01/90 - 06/30/91	1.2879	0.9967	450064	06/01/90 - 05/31/91	1.4387	0.9988
440104	07/01/90 - 06/30/91	1.4274	0.9976	450070	07/01/90 - 06/30/91	1.1118	0.9870
440109	07/01/90 - 06/30/91	1.0368	0.9507	450074	06/01/90 - 05/31/91	1.1344	0.9920
440111	07/01/90 - 06/30/91	1.2812	0.9864	450078	04/01/90 - 03/31/91	0.9854	0.9775
440114	07/01/90 - 06/30/91	1.0346	0.9600	450079	07/01/90 - 06/30/91	1.4451	0.9950
440115	07/01/90 - 06/30/91	1.1729	0.9781	450090	07/01/90 - 06/30/91	1.2122	0.9670
440121	07/01/90 - 06/30/91	1.1372	0.9866	450092	07/01/90 - 06/30/91	1.2667	0.9670
440128	07/01/90 - 06/30/91	0.9548	0.8204	450096	07/01/90 - 06/30/91	1.4947	0.9970
440130	07/01/90 - 06/30/91	1.1113	0.9826	450099	05/01/90 - 04/30/91	1.1759	0.9886
440131	07/01/90 - 06/30/91	1.1357	0.9678	450102	07/01/90 - 06/30/91	1.6731	0.9968
440132	07/01/90 - 06/30/91	1.0409	0.9631	450109	07/01/90 - 06/30/91	1.0051	0.9812
440133	07/01/90 - 06/30/91	1.4563	0.9988	450113	06/01/90 - 05/31/91	1.2182	0.9890
440135	07/01/90 - 06/30/91	1.3395	0.9934	450115	04/01/90 - 03/31/91	1.0947	0.9772
440137	07/01/90 - 06/30/91	1.0512	0.9722	450123	05/01/90 - 04/30/91	1.0807	0.9846
440141	07/01/90 - 06/30/91	0.8984	0.9648	450126	03/01/90 - 02/28/91	1.2034	0.9910
440142	07/01/90 - 06/30/91	0.9993	0.9857	450128	07/01/90 - 06/30/91	1.1681	0.9820
440143	06/01/90 - 05/31/91	1.0145	0.9492	450143	07/01/90 - 06/30/91	1.0052	0.9300
440144	06/01/90 - 05/31/91	1.1389	0.9783	450147	07/01/90 - 06/30/91	1.3377	0.9973
440147	07/01/90 - 06/30/91	0.7857	0.9968	450157	03/03/90 - 02/28/91	1.0072	0.9834
440151	05/01/90 - 04/30/91	1.1401	0.9568	450170	07/01/90 - 06/30/91	1.1541	0.9885
440152	07/01/90 - 06/30/91	1.5662	0.9896	450177	07/01/90 - 06/30/91	1.0633	0.9769
440153	07/01/90 - 06/30/91	0.9495	0.9660	450179	07/01/90 - 06/30/91	1.0180	0.9849
440156	04/01/90 - 03/31/91	1.3462	0.9992	450184	07/01/90 - 06/30/91	1.4702	0.9969
440159	07/01/90 - 06/30/91	1.1830	0.9904	450188	04/01/90 - 03/31/91	0.9583	0.9503

Table 9 -- 1991 Transfer Adjusted Case Mix Index and Transfer
Adjustment to Discharges for Capital Hospital-Specific
Rate Redeterminations

PROVIDER NUMBER	COST REPORTING PERIOD BEGIN	COST REPORTING PERIOD END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES	PROVIDER NUMBER	COST REPORTING PERIOD BEGIN	COST REPORTING PERIOD END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES
450190	07/01/90	06/30/91	1.2678	0.9900	450563	07/01/90	06/30/91	1.2228	0.9858
450217	07/01/90	06/30/91	0.8591	0.9888	450570	04/01/90	03/31/91	0.9889	0.9774
450219	06/01/90	05/31/91	1.1609	0.9453	450573	07/01/90	06/30/91	1.0415	0.9580
450221	07/01/90	06/30/91	0.9886	0.9830	450586	07/01/90	06/30/91	1.1139	0.9835
450222	04/01/90	03/31/91	1.6353	0.9921	450603	04/01/90	03/31/91	0.9061	0.9474
450233	07/01/90	06/30/91	1.0790	0.9797	450610	04/01/90	03/31/91	1.3818	0.9947
450235	07/01/90	06/30/91	1.0403	0.9836	450620	07/01/90	06/30/91	1.0911	0.9374
450241	05/27/90	05/31/91	0.9351	0.9653	450630	05/01/90	04/30/91	1.5898	0.9970
450249	07/01/90	06/30/91	0.9319	0.9568	450638	06/01/90	05/31/91	1.4657	0.9970
450258	06/01/90	05/31/91	1.1145	0.9364	450641	07/01/90	06/30/91	0.8780	0.9898
450269	05/01/90	04/30/91	0.9298	0.9673	450643	07/01/90	06/30/91	1.1757	0.9914
450270	04/01/90	03/31/91	1.1443	0.9786	450649	07/01/90	06/30/91	1.0414	0.9347
450278	07/01/90	06/30/91	0.9402	0.9309	450651	04/01/90	03/31/91	1.7284	0.9985
450288	04/01/90	03/31/91	1.1713	0.9856	450658	07/01/90	06/30/91	0.9943	0.9484
450289	04/01/90	03/31/91	1.2962	0.9976	450660	03/01/90	02/28/91	1.6355	0.9975
450307	05/01/90	04/30/91	0.8981	0.9677	450665	07/01/90	06/30/91	0.9835	0.9652
450309	06/01/90	05/31/91	1.0388	0.9531	450668	06/01/90	05/31/91	1.4893	0.9969
450320	04/01/90	03/31/91	1.2557	0.9908	450670	07/01/90	06/30/91	1.2219	0.9928
450324	07/01/90	06/30/91	1.5592	0.9962	450675	04/01/90	03/31/91	1.3255	0.9909
450325	07/01/90	06/30/91	1.2079	0.9849	450678	06/01/90	05/31/91	1.4577	0.9946
450341	04/01/90	03/31/91	0.9449	0.9994	450681	07/01/90	06/30/91	1.5172	0.9998
450349	07/01/90	06/30/91	1.1624	0.9699	450682	07/01/90	06/30/91	1.2568	0.9930
450351	06/01/90	05/31/91	1.2986	0.9871	450684	07/01/90	06/30/91	1.3312	0.9887
450362	07/01/90	06/30/91	0.9569	0.9591	450685	07/01/90	06/30/91	1.2529	0.9926
450366	04/01/90	03/31/91	1.6917	0.9957	450688	06/01/90	05/31/91	1.2984	0.9855
450370	05/01/90	04/30/91	1.2243	0.9776	450691	07/01/90	06/30/91	1.2668	0.9826
450372	07/01/90	06/30/91	1.3288	0.9776	450694	07/01/90	06/30/91	1.1783	0.9775
450379	06/01/90	05/31/91	1.6042	0.9966	450704	07/01/90	06/30/91	1.2890	0.9824
450381	04/01/90	03/31/91	0.8942	0.9622	450709	07/01/90	06/30/91	1.2506	0.9990
450393	03/01/90	02/28/91	1.2716	0.9931	450723	07/01/90	06/30/91	1.2264	0.9920
450395	06/01/90	05/31/91	1.0685	0.9692	450730	06/01/90	05/31/91	1.3905	0.9815
450400	07/01/90	06/30/91	1.0819	0.9441	450743	07/01/90	06/30/91	1.4399	0.9919
450411	07/01/90	06/30/91	1.0580	0.9620	450749	07/01/90	06/30/91	1.0371	0.9832
450417	01/17/90	01/16/91	1.0451	0.9661	450750	07/01/90	06/30/91	0.9907	0.9883
450418	04/01/90	03/31/91	1.3273	0.9835	450755	06/01/90	05/31/91	0.9754	0.9754
450447	05/01/90	04/30/91	1.3195	0.9896	450758	06/01/90	05/31/91	1.7706	0.9930
450451	07/01/90	06/30/91	1.0247	0.9566	450768	01/18/90	01/31/91	1.1565	0.9608
450457	06/01/90	05/31/91	1.5769	0.9998	460003	06/01/90	05/31/91	1.3985	0.9978
450460	07/01/90	06/30/91	0.9740	0.9791	460005	06/01/90	05/31/91	1.2538	0.9880
450467	07/01/90	06/30/91	1.0455	0.9670	460008	03/01/90	02/28/91	1.2910	0.9807
450469	07/01/90	06/30/91	1.2631	0.9938	460009	07/01/90	06/30/91	1.7523	0.9998
450473	06/01/90	05/31/91	1.0915	0.9826	460030	02/01/90	01/31/91	1.0594	0.9797
450476	07/01/90	06/30/91	0.9312	0.9234	460032	07/01/90	06/30/91	0.9438	1.0000
450486	07/01/90	06/30/91	0.9580	0.9418	460035	07/01/90	06/30/91	0.8822	0.9507
450489	04/01/90	03/31/91	1.0207	0.9457	460037	07/01/90	06/30/91	0.9613	0.9642
450497	07/01/90	06/30/91	1.1645	0.9709	490007	05/01/90	04/30/91	1.8798	0.9974
450498	07/01/90	06/30/91	1.0732	0.9735	490009	07/01/90	06/30/91	1.6345	0.9961
450508	07/01/90	06/30/91	1.3958	0.9951	490010	07/01/90	06/30/91	1.1715	0.9744
450517	07/01/90	06/30/91	0.9424	0.9739	490022	07/01/90	06/30/91	1.2138	0.9851
450537	06/01/90	05/31/91	1.3468	0.9916	490028	04/01/90	03/31/91	1.2815	0.9933
450545	07/01/90	06/30/91	1.2543	0.9986	490032	07/01/90	06/30/91	1.6112	0.9973
450546	06/01/90	05/31/91	1.3419	0.9859	490035	07/01/90	06/30/91	1.1647	0.9788
450551	04/01/90	03/31/91	1.0685	0.9622	490043	07/01/90	06/30/91	1.1543	0.9879

Table 9 -- 1991 Transfer Adjusted Case Mix Index and Transfer Adjustment to Discharges for Capital Hospital-Specific Rate Redeterminations

Page 20 of 21

PROVIDER NUMBER	COST REPORTING PERIOD BEGIN - END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES	PROVIDER NUMBER	COST REPORTING PERIOD BEGIN - END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES
490046	05/01/90 - 04/30/91	1.3366	0.9887	510080	07/01/90 - 06/30/91	0.9859	0.9584
490053	07/01/90 - 06/30/91	1.2123	0.9756	510086	07/01/90 - 06/30/91	1.1067	0.9862
490090	07/01/90 - 06/30/91	1.1490	0.9772	520004	07/01/90 - 06/30/91	1.2340	0.9936
490093	05/01/90 - 04/30/91	1.2694	0.9971	520006	03/01/90 - 02/28/91	1.0387	0.9591
490094	05/01/90 - 04/30/91	1.0960	0.9941	520007	07/01/90 - 06/30/91	1.0545	0.9723
490098	07/01/90 - 06/30/91	1.2722	0.9903	520009	07/01/90 - 06/30/91	1.4490	0.9933
490104	07/01/90 - 06/30/91	0.9212	0.9792	520011	04/01/90 - 03/31/91	1.0968	0.9818
490105	07/01/90 - 06/30/91	0.6928	0.9789	520013	07/01/90 - 06/30/91	1.2851	0.9941
490106	07/01/90 - 06/30/91	0.7939	0.9913	520015	07/01/90 - 06/30/91	1.1553	0.9600
490108	07/01/90 - 06/30/91	0.8653	0.9756	520016	07/01/90 - 06/30/91	0.9986	0.9658
490109	07/01/90 - 06/30/91	0.7984	0.9873	520017	07/01/90 - 06/30/91	1.1666	0.9832
490111	07/01/90 - 06/30/91	1.1696	0.9756	520025	07/01/90 - 06/30/91	1.1097	0.9735
490114	07/01/90 - 06/30/91	1.0166	0.9871	520027	07/01/90 - 06/30/91	1.1476	0.9804
490118	04/01/90 - 03/31/91	1.6558	0.9986	520028	07/01/90 - 06/30/91	1.3402	0.9918
490120	07/01/90 - 06/30/91	1.3022	0.9901	520030	07/01/90 - 06/30/91	1.5138	0.9962
490123	04/01/90 - 03/31/91	1.0860	0.9726	520040	07/01/90 - 06/30/91	1.4294	0.9912
490124	07/01/90 - 06/30/91	1.2596	0.9950	520041	07/01/90 - 06/30/91	1.1147	0.9678
490127	07/01/90 - 06/30/91	1.0633	0.9824	520044	07/01/90 - 06/30/91	1.3316	0.9918
490131	07/01/90 - 06/30/91	0.9289	0.9745	520047	04/01/90 - 03/31/91	0.9706	0.9512
500008	07/01/90 - 06/30/91	1.9072	0.9979	520051	07/01/90 - 06/30/91	2.0142	0.9993
500021	07/01/90 - 06/30/91	1.3337	0.9792	520063	07/01/90 - 06/30/91	1.1860	0.9785
500023	07/01/90 - 06/30/91	1.1630	0.9741	520066	07/01/90 - 06/30/91	1.2377	0.9903
500030	07/01/90 - 06/30/91	1.3389	0.9928	520068	07/01/90 - 06/30/91	1.0729	0.9730
500039	05/01/90 - 04/30/91	1.2937	0.9937	520074	07/01/90 - 06/30/91	1.1601	0.9753
500041	07/01/90 - 06/30/91	1.1912	0.9815	520075	07/01/90 - 06/30/91	1.3792	0.9962
500064	07/01/90 - 06/30/91	1.5890	0.9886	520076	07/01/90 - 06/30/91	1.1635	0.9850
500076	04/01/90 - 03/31/91	1.3026	0.9915	520087	04/16/90 - 04/14/91	1.5118	0.9983
500086	07/01/90 - 06/30/91	1.3282	0.9768	520088	07/01/90 - 06/30/91	1.2200	0.9807
500104	04/01/90 - 03/31/91	1.2826	0.9610	520091	04/01/90 - 03/31/91	1.2625	0.9846
500108	07/01/90 - 06/30/91	1.6463	0.9984	520092	05/01/90 - 04/30/91	1.1784	0.9606
500127	07/01/90 - 06/30/91	1.0645	0.9883	520096	07/01/90 - 06/30/91	1.4205	0.9969
500135	07/01/90 - 06/30/91	1.0307	0.9830	520097	07/01/90 - 06/30/91	1.2820	0.9913
500137	06/01/90 - 05/31/91	0.9085	1.0000	520098	07/01/90 - 06/30/91	1.6765	0.9951
500138	07/01/90 - 06/30/91	4.8258	1.0000	520104	06/01/90 - 05/31/91	0.9966	0.9400
500139	02/01/90 - 01/31/91	1.3184	0.9936	520111	07/01/90 - 06/30/91	1.1364	0.9737
500141	07/01/90 - 06/30/91	1.2357	0.9769	520112	07/01/90 - 06/30/91	1.1154	0.9735
510015	07/01/90 - 06/30/91	0.9353	0.9597	520114	07/01/90 - 06/30/91	1.0966	0.9791
510020	07/01/90 - 06/30/91	1.1141	0.9791	520120	07/01/90 - 06/30/91	1.0999	0.9781
510023	07/01/90 - 06/30/91	1.0212	0.9881	520121	07/01/90 - 06/30/91	0.9666	0.9653
510024	07/01/90 - 06/30/91	1.3061	0.9995	520122	07/01/90 - 06/30/91	1.0134	0.9647
510025	07/01/90 - 06/30/91	0.9291	0.9608	520124	04/01/90 - 03/31/91	1.1020	0.9744
510026	07/01/90 - 06/30/91	0.9857	0.9729	520132	05/01/90 - 04/30/91	1.2279	0.9747
510027	07/01/90 - 06/30/91	1.0185	0.9217	520134	07/01/90 - 06/30/91	1.1202	0.9821
510035	07/01/90 - 06/30/91	1.0466	0.9639	520136	07/01/90 - 06/30/91	1.4663	0.9975
510036	07/01/90 - 06/30/91	1.1452	0.9758	520141	07/01/90 - 06/30/91	1.1416	0.9549
510043	07/01/90 - 06/30/91	0.9712	0.9573	520142	07/01/90 - 06/30/91	0.9788	0.9618
510046	07/01/90 - 06/30/91	1.2645	0.9929	520151	03/01/90 - 02/28/91	1.0810	0.9600
510058	07/01/90 - 06/30/91	1.1910	0.9949	520159	04/01/90 - 03/31/91	0.9121	0.9564
510061	07/01/90 - 06/30/91	1.0755	0.9693	520161	04/01/90 - 03/31/91	1.1091	0.9579
510062	07/01/90 - 06/30/91	1.1662	0.9935	520170	07/01/90 - 06/30/91	1.2614	0.9877
510070	06/01/90 - 05/31/91	1.1767	0.9916	520176	07/01/90 - 06/30/91	0.8486	1.0000
510071	07/01/90 - 06/30/91	1.2691	0.9881	520178	07/01/90 - 06/30/91	1.1520	0.9558
510072	07/01/90 - 06/30/91	1.0167	0.9763	520180	07/01/90 - 06/30/91	0.7340	0.9907

Table 9 -- 1991 Transfer Adjusted Case Mix Index and Transfer
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Rate Redeterminations

Page 21 of 21

PROVIDER NUMBER	COST REPORTING PERIOD BEGIN - END	TRANSFER ADJUSTED		TRANSFER ADJUSTMENT TO DISCHARGES
		CASE MIX INDEX		
530001	06/01/90 - 05/31/91	1.2612		0.9975
530002	07/01/90 - 06/30/91	1.1473		0.9727
530003	07/01/90 - 06/30/91	0.9898		0.9248
530004	07/01/90 - 06/30/91	0.9709		0.9593
530005	07/01/90 - 06/30/91	1.0754		1.0000
530006	07/01/90 - 06/30/91	1.1214		0.9885
530007	07/01/90 - 06/30/91	1.0385		0.9438
530009	07/01/90 - 06/30/91	0.9655		0.9781
530011	07/01/90 - 06/30/91	1.1226		0.9782
530012	07/01/90 - 06/30/91	1.6146		0.9954
530014	07/01/90 - 06/30/91	1.1026		0.9953
530015	07/01/90 - 06/30/91	1.1318		0.9785
530016	07/01/90 - 06/30/91	1.1586		0.9954
530017	07/01/90 - 06/30/91	0.9973		0.9781
530018	07/01/90 - 06/30/91	1.0510		0.9667
530019	07/01/90 - 06/30/91	0.9685		0.9951
530022	07/01/90 - 06/30/91	1.1265		0.9460
530025	07/01/90 - 06/30/91	1.2447		0.9780
530026	07/01/90 - 06/30/91	1.0658		0.9790
530027	07/01/90 - 06/30/91	0.8558		0.9615
530029	07/01/90 - 06/30/91	0.9180		0.9431
530031	07/01/90 - 06/30/91	1.0417		0.9186

BILLING CODE 4120-01-C

APPENDIX A—REGULATORY IMPACT ANALYSIS

I. Introduction

Executive Order (E.O.) 12291 requires us to prepare and publish an initial regulatory impact analysis for any proposed rule that meets one of the E.O. 12291 criteria for a "major rule;" that is, a rule that would be likely to result in—

- An annual effect on the economy of \$100 million or more;
- A major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or
- A significant adverse effect on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

In addition, we generally prepare a regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (RFA)(5 U.S.C. 601 through 612), unless the Secretary certifies that a proposed rule would not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, we consider all hospitals to be small entities.

Also, section 1102(b) of the Act requires the Secretary to prepare a regulatory impact analysis for any proposed rule that may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital with fewer than 100 beds and that is located outside of a Metropolitan Statistical Area or New England County Metropolitan Area.

Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98-21) designated hospitals in certain New England counties as belonging to the adjacent New England Metropolitan County. Thus, for purposes of the prospective payment system, we classified these hospitals as urban hospitals.

It is clear that the changes being implemented in this document would affect both a substantial number of small rural hospitals as well as other classes of hospitals, and the effects on some may be significant. Therefore, the discussion below, in combination with the rest of this proposed rule, constitutes a combined regulatory impact analysis and regulatory flexibility analysis in

accordance with E.O. 12291 and the RFA.

II. Objectives

The prospective payment rates for both capital and operating costs create incentives similar to the incentives a hospital faces in pricing and marketing its services in a price competitive market. Under the prospective payment systems, similar hospitals are paid the same rate for similar services, and hospitals know in advance the amount they will be paid per discharge. Because hospitals receive this payment regardless of their specific cost experience, there are strong incentives to operate more efficiently and to minimize unnecessary costs. Our specific objectives include the following:

- Restructuring hospitals' economic incentives.
- Basing payment on a system that more accurately identifies the product being purchased than cost reimbursement.
- Reinforcing the role of the Federal government as a prudent buyer of services.
- Restraining the rate of hospital cost increases, thus moderating the outflow of expenditures from the Medicare trust fund while maintaining high quality care.

In addition, we share national goals of deficit reduction and restraints on government spending in general. We believe the proposed changes would further all of the above goals while maintaining the financial viability of the hospital industry and ensuring access to high quality care for beneficiaries. We expect that these proposed changes would ensure that the outcomes of this payment system are, in general, reasonable and equitable while avoiding or minimizing unintended adverse consequences. Thus, our overall intent is to refine further the prospective payment system without undercutting our objectives.

III. Limitations of Our Analysis

As has been the case in previously published regulatory impact analyses, the following quantitative analysis is limited to presenting the projected effects of the proposed policy and rate changes on current and projected payment rates. In the analysis that follows, we examine the effects on hospital payments of changes required by statute and changes HCFA is proposing. We accomplish this by projecting estimated payments under each set of proposed policy changes onto current estimated payments and determining the difference between the two sets of payment amounts. That is,

we project the effects of each policy change on payments while holding all other payment variables constant. Thus, we are not attempting to predict behavioral responses to our policy changes, and we are not generally accounting for changes in such exogenous variables as admissions, lengths of stay, or case mix. We believe that this approach to the specific impact discussions below is the most reasonable one given the difficulty we have in quantifying impacts and attributing causality. Wherever possible, we have included quantitative representations of the impact of changes being proposed in this document.

As we have done in previous impact analyses, we are soliciting comments and information about the anticipated effects of these changes on the prospective payment system.

IV. Hospitals Included in and Excluded From the Prospective Payment System

The prospective payment systems for hospital inpatient operating and capital-related costs encompass nearly all general, short-term, acute care hospitals that participate in the Medicare program. Only 59 short-term, acute care hospitals remain excluded from the prospective payment systems under section 1814(b)(3) of the Act (in Maryland) or a demonstration project (in the Finger Lakes region of New York State). Thus, as of April 9, 1992, about 5,390 hospitals were receiving prospectively based payments for performing inpatient services. This represents about 83 percent of all Medicare-participating hospitals.

Among the 5,390 prospective payment hospitals, there are over 860 hospitals that are paid on special bases under the prospective payment system for operating costs, as required by statute, as sole community hospitals or rural referral centers. In addition, there are approximately 1,602 hospitals that are receiving additional payments on the basis of being classified as disproportionate share hospitals. About 30 of these hospitals also receive special payments as rural referral centers and 95 as sole community hospitals. About 1,207 hospitals are receiving additional payments for the indirect cost of medical education. There are about 605 hospitals that qualify for additional payments under both the indirect medical education and disproportionate share payment provisions under the prospective payment system for operating costs.

Section 1886(d)(5)(G)(i) of the Act directs the Secretary to pay Medicare-dependent, small rural hospitals on the

basis of the greater of a hospital-specific rate based on their FY 1982 or FY 1987 operating costs per discharge, whichever is higher, or the applicable standardized payment amount. This provision was effective with cost reporting periods beginning after April 1, 1990 and expires with cost reporting periods ending on or before March 31, 1993. Thus, with cost reporting periods beginning after April 1, 1992, over 500 hospitals that meet the criteria for being Medicare-dependent, small rural hospitals will begin receiving only the standardized amount payments.

Under the capital prospective payment system, there are special payment protections for sole community hospitals and for urban hospitals with more than 100 beds and a disproportionate share patient percentage of 20.2 percent or more or which derive at least 30 percent of their total inpatient revenues from State or local government sources for the care of indigent patients. Approximately 532 sole community hospitals and 761 urban hospitals qualify for this protection. An additional 1,486 urban hospitals with more than 100 beds receive additional payments for serving low income patients. (An additional payment is made to all urban hospitals with more than 100 beds that serve low income patients.) Additional payments are also made to 1,207 hospitals with graduate medical education teaching programs.

As of April 9, 1992, about 1,050 Medicare hospitals are excluded by statute from the prospective payment system and continue to be paid on the basis of their reasonable costs, subject to limits on the rate of increase in their costs. These hospitals include psychiatric, rehabilitation, long-term care, and children's hospitals. Another 1,893 psychiatric and rehabilitation units in hospitals subject to the prospective payment system are excluded from the prospective payment system as of the same date. These units, too, are paid on the basis of reasonable cost subject to limits on the rate of increase in their costs. In addition, there are nine hospitals extensively involved either in the treatment of cancer or cancer research that are excluded from the prospective payment system.

V. Impact on Excluded Hospitals and Units

As noted in the previous section of this impact analysis, approximately 1,050 excluded Medicare hospitals and 1,893 units in hospitals included in the prospective payments systems are paid on a reasonable cost basis subject to the rate-of-increase ceiling requirement of § 413.40. For hospital cost reporting periods beginning on or after October 1,

1992, excluded hospitals and units would be paid the full increase in their reasonable costs up to the percentage increase in the hospital market basket. We are projecting an increase in the excluded hospital market basket of 4.5 percent.

The impact on excluded hospitals and units of the proposed update in the rate-of-increase limit depends on the rate of cost increases experienced by each hospital and excluded unit since its base period. For excluded hospitals and units with per-case increases in inpatient operating costs below the cumulative update in their rate-of-increase limit, the major effect will be on the level of incentive payments these hospitals and units receive. Conversely, for excluded hospitals and units with per-case cost increases above the cumulative update in their rate-of-increase limit, the major effect will be the amount of excess costs that the hospitals would have to absorb.

In this context, we note that for cost reporting periods beginning in FY 1992, § 413.40(d)(3)(iii) allows an excluded hospital or unit whose cost exceed the rate-of-increase limit to receive the lower of its target amount plus 50 percent of reasonable costs in excess of the target amount or 110 percent of the target amount. In addition, under the various provisions set forth in § 413.40, excluded hospitals and units can obtain substantial relief from the rate-of-increase limit for significant, yet justifiable, increases in operating costs that exceed the limit. At the same time, however, by generally limiting payment increases to the growth rate in the hospital market basket, we continue to provide an incentive for excluded hospitals and units to restrain the growth in their spending for patient services.

VI. Quantitative Impact Analysis of the Proposed Policy Changes Under Prospective Payment System for Operating Costs

A. Basis and Methodology of Estimates

In this proposed rule, we are announcing policy changes and payment rate updates for the prospective payment systems for operating costs and for capital-related costs. We have prepared separate analyses of the proposed changes to each system.

The data used in developing the quantitative analyses of changes in operating payments that are presented below are taken from FY 1991 billing data and the most current hospital-specific data. For purposes of determining which method of payment to apply for sole community hospitals (the Federal payment rate or the

applicable hospital-specific payment rate as prescribed by section 1886(d)(5)(D)(i) of the Act), we assume that all sole community hospitals have a cost reporting period that coincides with the Federal fiscal year.

Our analysis has several limitations. First, it does not take into account behavioral changes that hospitals may adopt in response to the policy changes being implemented in this proposed rule. Second, as a result of gaps in our data, we are unable to quantify some of the effects of the changes contained in this rule. Third, we could not categorize all the hospitals in our data base because in some cases the hospital-specific data necessary for constructing our impact model were missing. For some hospitals, data on hospital bed size and type of ownership were missing. The missing data, however, did not prevent us from using the discharges from these facilities to estimate the actual payments for FY 1992 and the projected FY 1993 payments under the policies proposed that serve as the bases of our simulation.

To illustrate the effects of hospital geographic reclassifications for FY 1993, we are dividing the analysis presented in Table I into two parts. The first part shows changes in payments to hospitals based on their actual geographic location. The second part of the analysis shows changes in payments based on a hospital's FY 1993 geographic classification for purposes of the standardized amount under the prospective payment system after any reclassifications under sections 1886(d)(8) or (10) of the Act, rather than its actual geographic location. For example, our analysis in Table I of hospital operating payments based on actual geographic location shows that the number of hospitals in large urban, other urban, and rural areas is 1,467, 1,411, and 2,516, respectively. The analysis of hospitals that incorporates reclassifications shows the number of large urban, other urban, and rural hospitals to be 1,619, 1,480, and 2,295, respectively. The effects of geographic reclassification are evident from a comparison of the two analyses within Table I.

To simulate the impact of the expiration of section 1886(d)(5)(G) of the Act on payments to Medicare-dependent, small rural hospitals (MDHs), we computed hospital-specific payments from October 1, 1992 through the end of each hospital's cost reporting period that ends on or before March 31, 1993. That is, we simulated payments for this period based on the higher of the hospital-specific payment or the

proposed FY 1993 standardized amount payments for operating costs. We then computed payments for the remainder of the Federal fiscal year based on the proposed FY 1993 standardized amount payments for operating costs. For example, if the hospital's cost reporting period ends December 31 and the hospital-specific payments are higher than the proposed standardized amount payments, we computed hospital-specific payments for 3 months and prospective payments for 9 months. In the simulation, hospitals with cost reporting periods ending before September 30, were paid on the basis of the Federal payment rates for the entire period. Since some of these hospitals lose this special protection during FY 1992, a similar simulation was performed to reduce FY 1992 payments for comparison purposes. Below we present the annual effect of the expiration of the special provision on payments to Medicare-dependent, small rural hospitals. We simulated a full 12 months of payments under the special payment provision compared with 12

months of payment without benefit of the provision.

Average FY 1993 payment/case 12 months payment as an MDH	Average payment/case 12 months payment without the MDH payment protection	Percent change
\$3,502	\$3,138	-10.4

The analysis in Table I examines the following major changes set forth in this proposed rule—

- The effects of the annual reclassification of diagnoses and procedures and the recalibration of the DRG weights required by section 1886(d)(4)(C) of the Act (column 1).
- The effects of hospital reclassifications by the MGCRB (column 2).
- The effect of the proposed outlier payment changes (using a marginal cost factor of .55 and the arithmetic mean to calculate day outlier payments) and increase in outlier payment levels (column 3).

• The combined effect of all changes being presented in this proposed rule (column 4).

In order to present the effects of the separate policy proposals displayed in columns 1, 2, and 3 of table I, we added incrementally the payment variables associated with the provision under examination, so that the percentages in the columns represent the difference in payments relative to the previous column. For example, column 2 (Geographic Reclassification) examines the impact of the standardized amount and wage index changes resulting from geographic reclassifications given the DRG reclassifications and recalibration results displayed in column 1 of Table I. The last column in Table I displays the combined effects of the previous columns as well as, corrections to the wage index values, the phase-out of the MDH Provision, and the update and budget neutrality factors. Thus, the last column is the only one that reflects the effects of all the quantifiable proposed policy changes on simulated FY 1992 payments.

TABLE I.—IMPACT ANALYSIS OF PROPOSED OPERATING COST PROSPECTIVE PAYMENT SYSTEM CHANGES FOR FY 1993

	Number of hospitals ¹	DRG reclassification and recalibration (1) ²	Geographic reclassification (2) ³	Outlier payment changes			All changes (4) ⁴
				Payment level adjustment (3A) ⁴	Proposed Policy (3B) ⁵	Sum of (A) and (B) (3C)	
By Geographic Location							
All hospitals	5,394	0.0	0.0	1.6	0.0	1.6	4.3
Large urban areas (populations over 1 million)	1,467	.0	-.1	1.9	+.2	1.7	4.5
Other urban areas (populations of 1 million or fewer)	1,411	.0	.0	1.7	.1	1.8	4.6
Rural Areas	2,516	-.1	.1	.7	.0	.7	3.3
Urban Hospitals	2,878	.0	.0	1.8	.1	1.7	4.5
0-99 beds	670	-.1	-.1	1.1	.2	1.3	4.0
100-199 beds	859	.1	.0	1.4	.2	1.6	4.4
200-299 beds	614	.1	.0	1.7	.1	1.8	4.6
300-499 beds	536	.0	.2	1.9	.1	1.8	4.5
500 or more beds	199	.0	.0	2.2	.4	1.8	4.6
Rural Hospitals	2,516	.1	.1	.7	.0	.7	3.3
0-49 beds	1,239	.2	.3	.2	.0	.2	2.0
50-99 beds	767	.1	.3	.4	.0	.4	2.8
100-149 beds	264	.0	.1	.7	.1	.8	3.5
150-199 beds	128	.0	.2	.8	.0	.8	4.2
200 or more beds	116	.0	.4	1.2	.0	1.2	3.8
Urban by Region:							
New England	172	.2	.2	1.8	-.3	1.5	4.3
Middle Atlantic	460	.3	-.1	2.6	-.1.3	1.3	4.2
South Atlantic	418	-.1	.0	1.9	.3	2.2	4.9
East North Central	475	.0	-.2	1.4	.3	1.7	4.3
East South Central	168	.1	-.1	1.8	.4	2.2	5.0
West North Central	183	.0	-.3	1.4	.4	1.8	4.3
West South Central	352	.1	.4	1.7	.6	2.3	5.6
Mountain	110	-.1	-.3	1.6	.6	2.2	4.6
Pacific	492	-.2	.0	1.4	.4	1.8	4.4
Puerto Rico	48	.2	-.2	.9	.1	1.0	3.7
Rural by region:							
New England	57	-.1	-.1	.9	.0	.9	4.3
Middle Atlantic	93	.0	-.4	1.3	-.7	.6	2.0
South Atlantic	343	.0	-.7	1.1	-.1	1.0	3.4
East North Central	348	.0	.6	.4	.1	.5	3.2
East South Central	298	.0	.0	.6	.1	.7	3.6
West North Central	564	-.1	.5	.3	.1	.4	2.5
West South Central	401	-.1	.7	.5	.2	.7	3.5
Mountain	241	-.1	.2	.3	.1	.4	4.1

TABLE I.—IMPACT ANALYSIS OF PROPOSED OPERATING COST PROSPECTIVE PAYMENT SYSTEM CHANGES FOR FY 1993—Continued

	Number of hospitals ¹	DRG reclassification and recalibration (1) ²	Geographic reclassification (2) ³	Outlier payment changes			All changes (4) ⁴
				Payment level adjustment (3A) ⁴	Proposed Policy (3B) ⁵	Sum of (A) and (B) (3C)	
Pacific	166	.0	.5	.5	.2	.7	4.2
Puerto Rico	7	.0	-.4	.3	.0	.3	3.7
By Payment Classification							
All hospitals	5,394	.0	.0	1.6	0.0	1.6	4.3
Large Urban areas (populations over 1 million)	1,619	.0	.0	1.9	-.01	1.8	4.5
Other urban areas (populations of 1 million or fewer)	1,480	.0	.0	1.6	.1	1.7	4.5
Rural areas	2,295	-.1	-.1	.6	.0	.6	3.1
Teaching status:							
Non-teaching	4,186	.0	.0	1.3	.2	1.5	4.2
Resident/bed ratio less than 0.25	968	.0	-.1	1.7	-.1	1.6	4.4
Resident/bed ratio 0.25 or greater	239	.0	.0	2.3	-.6	1.7	4.5
Disproportionate share hospitals (DSH):							
Non-DSH	3,792	.0	.0	1.5	.1	1.6	4.3
Urban DSH:							
100 Beds or more	1,133	.1	.0	1.9	-.3	1.6	4.5
Fewer than 100 beds	95	-.1	.1	.8	.3	1.1	3.9
Rural DSH:							
Sole Community (SCH)	95	-.1	-.4	0.2	.0	.2	3.4
Referral centers (RRC)	44	.0	.0	1.1	-.2	.9	3.7
Other rural DSH hospitals:							
100 beds or more	62	.0	-.28	1.0	-.2	.8	1.6
Fewer than 100 beds	173	.2	.0	.3	.0	.3	3.0
Urban teaching and DSH							
Both teaching and DSH	605	.1	.0	2.1	-.4	1.7	4.5
Teaching and no DSH	516	-.1	-.1	1.8	.1	1.9	4.5
No Teaching and DSH	623	.1	.1	1.5	.1	1.6	4.5
No Teaching and no DSH	1,355	.0	.0	1.6	.3	1.9	4.7
Rural hospital types:							
Non special status hospitals	1,010	-.1	-.8	.6	.0	.6	3.5
RRC	179	.0	.4	1.0	.1	1.1	4.3
SCH	532	-.1	.0	.1	.0	.1	4.1
Medicare-Dependent hospitals (MDH)	515	-.2	.3	.2	.0	.2	4.3
SCH and RRC	45	.1	.3	.6	-.2	.4	4.3
SCH and MDH	1,092	-.1	.2	.3	-.1	.2	1.6
Hospitals Reclassified by the Medicare Geographic Classification Review Board							
Reclassification status during FY 92 and FY 93:							
Reclassified during both FY 92 and FY 93	847	.0	-.7	1.2	.0	1.2	3.4
Reclassified during FY 93 only	349	.1	4.1	1.7	-.3	1.4	8.3
Reclassified during FY 92 only	82	.0	-.3.6	1.1	.1	1.2	0.5
FY 93 reclassifications:							
All reclassified hospitals	1,196	.0	.9	1.3	-.1	1.2	5.0
All nonreclassified	4,148	.0	-.3	1.7	.0	1.7	4.2
All urban reclassified hospitals	376	.1	1.2	1.7	-.2	1.5	5.7
Urban nonreclassified hospitals	2,502	.0	-.3	1.8	.0	1.8	4.3
All reclassified rural hospitals	820	.0	.4	.8	.0	.8	4.0
Rural nonreclassified hospitals	1,646	-.1	-.3	.4	.0	.4	2.2
Other reclassified hospitals (section 1886(D)(8)(B))	50	.0	.1	1.1	.1	1.2	4.1
Type of ownership:							
Voluntary	3,188	.0	-.1	1.7	-.1	1.6	4.3
Proprietary	749	.0	.0	1.7	.4	2.1	4.9
Government	1,457	.0	.2	1.3	.0	1.3	4.1
Medicare utilization as a percent of inpatient days:							
0-25	277	.1	.2	1.6	-.1	1.5	4.6
25-50	1,934	.0	.0	1.7	.0	1.7	4.5
50-65	2,213	.0	.0	1.5	.0	1.5	4.3
Over 65	727	.0	-.2	1.2	.0	1.2	2.9

¹ Because data necessary to classify some hospitals by category were missing, these hospitals were omitted from the analysis. Therefore, the total number of hospitals in each category may not equal the national total. Hospital-specific data and discharges data are from FY 1991, and hospital cost report data are from reporting periods beginning in FY 1990.

² Recalibration of the DRG weights and classification changes are based on FY 1991 MEDPAR data and are performed annually in accordance with section 1886(d)(4)(C) of the Act.

³ Under section 1886(d)(10) of the Act, a hospital may apply to the Medicare Geographic Classification Review Board for the purpose of obtaining a higher wage index, standardized payment amount, or both. Under section 1886(d)(8)(D) of the Act, changes in the geographic designation of hospitals must be budget neutral and payments to rural hospitals after reclassification cannot be lower than they would be absent reclassification. This column reflects the impact of changes in reclassifications between FY 1992 and FY 1993.

⁴ This column displays the effects of increasing outlier payments between FY 1992 and FY 1993. The thresholds implemented for FY 1992 were intended to result in 5.1 percent of payments for outlier cases. FY 1992 outlier payments now are estimated to equal 3.6 percent of total prospective payments. FY 1993 outlier payments are estimated at 5.1 percent.

⁵ This column displays the impact of the proposed change for computing day outlier cases: using the arithmetic mean length of stay in place of the geometric mean length of stay for computing the per diem payment amount, and using a marginal cost factor of .55 instead of .60.

⁶ This column shows the combined effects of all the previous columns as well as the effects of updating the FY 1992 standardized payment amounts by the rates of increase as mandated by section 1886(b)(3)(B)(i)(VII) of the Act. It also reflects the phase-out of the Medicare dependent, small rural hospital provision. In addition, this column captures interactive effects that we are not able to quantify.

B. The Impact of the Proposed Changes to the DRG Weights (Column 1)

In column 1 of Table I, we present the combined effects of the revised DRG classification system, and the subsequent recalibration of the DRG weights incorporating these redefined DRGs. Section 1886(d)(4)(C)(i) of the Act requires us each year to make appropriate classification changes and recalibrate the DRG weights in order to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources. The impact of reclassification and recalibration on aggregate payments is required by section 1886(d)(4)(C)(iii) of the Act to be budget neutral.

The redistributive impact of the proposed classification and recalibration changes across hospital groupings is small. At most, the impact is either a reduction or an increase of 0.3 percent for a few hospital groupings while most hospitals appear to experience no effect. The reductions are concentrated among small urban and rural hospitals. Rural hospitals with fewer than 50 beds are projected to lose an average of 0.2 percent in payments per case, and rural hospitals with between 50 and 99 beds are projected to lose 0.1 percent of their payments. Also, urban hospitals with fewer than 100 beds can expect an average 0.1 percent reduction in payments per case. However, urban hospitals with between 100 and 299 beds can expect an average increase in payments of 0.1 percent.

C. The Impact of MGCRB Reclassification on Hospitals (Column 2)

1. Impact of Current Policies

Section 1886(d)(10) of the Act provides for the establishment of the Medicare Geographic Classification Review Board (MGCRB). The MGCRB considers applications by hospitals for geographic reclassification for purposes of receiving a different wage index value, standardized amount, or both under the prospective payment system. By March 30 of each year, the MGCRB makes reclassification determinations that will be effective for the next fiscal year beginning on October 1. The first hospital reclassifications based on decisions of the MGCRB for FY 1992 were effective October 1, 1991. The MGCRB may reclassify a hospital to an adjacent urban area or to another rural area with which it has a close proximity for the purposes of using the other area's standardized amount, wage index value, or both. (A rural referral center or a sole community hospital may be redesignated to an area that is not an adjacent county.)

The proposed FY 1993 standardized payment amounts and wage index values incorporate all the MGCRB's reclassification decisions that will be effective for FY 1993. The MGCRB approved 1,249 hospital reclassifications for FY 1993. This number includes 50 hospitals that have also been reclassified under provisions of section 1886(d)(8)(B) of the Act that deems certain rural counties adjacent to one or more urban areas as belonging to the urban area.

The wage index values also reflect any decisions made by the HCFA Administrator through the appeals and

review process for MGCRB decisions as of March 30, 1991. Additional changes that result from the Administrator's review of MGCRB decisions will be incorporated into the wage index values and standardized payment amounts to be published in the final rule implementing changes to the prospective payment system for FY 1993.

The later Administrator decisions may affect the wage index value for specific geographic areas. These decisions may also determine whether a redesignated hospital receives the wage index of the area to which it is redesignated or a combined wage index that includes the data for both the hospitals already in the area and the redesignated hospitals.

Over 68 percent of all hospitals reclassified for FY 1993 are located in rural areas (820 hospitals). This represents almost 33 percent of all rural hospitals in our data base. Of the total number of rural hospitals that were reclassified, 79 percent (647 hospitals) were reclassified for purposes of their wage index. Ten percent of rural reclassified hospitals were reclassified for purposes of their standardized amounts and about 11 percent were granted reclassification for purposes of both their wage index and their standardized payment amount.

Among the 245 hospitals located in other urban areas that were reclassified for FY 1993, almost 57 percent (140 hospitals) were reclassified for purposes of increasing their wage index value. Another 36 percent (89 hospitals) were reclassified for purposes of both their wage index value and standardized amount. The following table shows the number (and percentage) of reclassified hospitals by their actual geographic location.

DISTRIBUTION OF RECLASSIFIED HOSPITALS

Geographic location	Total No. of hospitals reclassified	Reclassified for both wage index value and standardized amount		Reclassified for standardized amount		Reclassified for wage index	
		Number	Percent	Number	Percent	Number	Percent
Large Urban.....	131	6	5	0	0	125	95
Other Urban.....	245	89	36	16	7	140	56
Rural.....	820	93	11	80	10	647	79
Total.....	1196	188	16	96	8	912	76

Overall, 76 percent of the reclassified hospitals (912 hospitals) were reclassified for purposes of their wage index value, 8 percent (96 hospitals) were reclassified for purposes of their standardized amounts, and 16 percent (188 hospitals) were reclassified for purposes of both their wage index value and standardized payment amount.

We conducted an analysis that shows the effects of reclassification on payments to reclassified and non-reclassified hospitals in FY 1993. This analysis is presented in Table II, below. This analysis compares reclassified hospital payments for FY 1993 with payment levels that assume reclassified hospitals are paid on the basis of their

geographic location rather than reclassified location. In this respect, the analysis in Table II is comparable to the analysis we presented in the August 30, 1991 final rule (56 FR 43350).

Table II shows the changes in payments per case for all FY 1993 reclassified and nonreclassified hospitals in urban and rural locations

for each of the three reclassification categories.

As evidenced by the increase in payment for reclassified hospitals and the decrease in payments for non-reclassified hospitals, the effects of the MGCRB reclassification decisions are significant. The overall impact on reclassified hospitals would be to increase their payments per case by an average of 4.4 percent for FY 1993. Hospitals located in rural areas that were reclassified for purposes of both their wage index value and their standardized amount would receive the largest percentage increase in payments per case. They could expect an average increase of nearly 15.1 percent above what they would receive without reclassification. The 16 hospitals located in urban areas that were reclassified for purposes of their standardized amounts would receive an average decrease in

payments per case of 0.5 percent compared to what they would receive if there were no reclassifications. This outcome reflects the effects of the budget neutrality adjustment for urban hospitals and the reclassification of other hospitals from their labor market area. Thus, for the hospitals remaining in the labor market area after the wage index reclassifications, on average the decrease in the wage index value for the area would be greater than the increase in their standardized amount after reclassification to a large urban area.

The reclassification of hospitals primarily affects payment to nonreclassified hospitals through changes in the wage index and through the geographic reclassification budget neutrality adjustment required by section 1886(d)(8)(D) of the Act. Among hospitals that were not reclassified, the overall impact of hospital

reclassifications would be an average decrease in payments per case of about 1.2 percent. Non-reclassified urban hospitals (comprising about 61 percent of non-reclassified hospitals) would experience a 1.3 percent decrease in payments per case compared to what they would receive if there were no reclassifications. The 0.2 percent increase for nonreclassified rural hospitals is largely attributable to a redistribution of outlier payments between nonreclassified rural hospitals and hospitals that are reclassified for wage index purposes only. In the aggregate, payments to hospitals that are receiving the rural standardized payment amounts are budget neutral (except with respect to wage index only reclassifications, which are accounted for in the budget neutrality adjustment to the urban standardized amount).

TABLE II.—Effects on Payments Per Case of Geographic Reclassification of Hospitals Under Current Reclassification Policies

	Number of hospitals	(a)	(b)	(c)
		Payment per case without reclassification ¹	Payment per case after reclassification	Percent change in payment per case due to reclassification only ²
FY 93 reclassifications:				
All reclassified hospitals.....	1,196	5,009	5,231	4.4
Standardized amount only	96	4,879	5,003	2.6
Wage index only	912	5,017	5,219	4.0
Both	188	5,009	5,323	6.3
All urban reclassified hospitals	376	5,981	6,128	2.5
Standardized amount only	16	6,826	6,791	-0.5
Wage index only	265	6,163	6,297	2.2
Both	95	5,427	5,628	3.7
All reclassified rural hospitals	820	4,004	4,302	7.4
Standardized amount only	80	3,683	3,906	6.1
Wage index only	647	4,031	4,293	6.5
Both	93	3,959	4,555	15.1
All nonreclassified hospitals	4,148	6,003	5,932	-1.2
Urban non-reclassified hospitals	2,502	6,361	6,279	-1.3
Rural non-reclassified hospitals	1,646	3,544	3,549	0.2

¹ This column shows payments without regard to any previous MGCRB reclassification decision. This column reflects the fact that reclassifications are in effect for only 1 fiscal year.

² This column only shows the percentage change in payments resulting from decisions of the MGCRB for FY 1993. It does not reflect other changes such as outliers, DRG recalibration & reclassification or the update.

Table I shows the impact of changes in reclassification status between FY 1992 and FY 1993. The percentage change shown in Column 2 compares current payments (that include payments to currently reclassified hospitals) with payments based on the FY 1993 MGCRB decisions. For example, for hospitals that were reclassified in FY 1992, only the difference between their FY 1992 and FY 1993 payments that is attributable to FY 1993 MGCRB decisions is shown. For hospitals that were reclassified in both FY 1992 and FY 1993, the effect of the increased number of MGCRB reclassifications would be to reduce their payments by 0.7 percent. Hospitals that were reclassified in FY 1993 only would

experience a 4.1 percent increase in payments, while those hospitals that were reclassified in FY 1992 but not in FY 1993 would experience a 3.6 percent reduction in payment as a result of no longer being reclassified. Overall payments to rural hospitals are expected to increase by an average of 0.1 percent. However, payments to rural hospitals with fewer than 100 beds are projected to increase by 0.3 percent, while payments to rural hospitals with 200 or more beds are expected to decrease by 0.4 percent. Among urban hospitals, we expect hospitals with between 300 and 499 beds to receive an average decrease of 0.2 percent in payments compared with FY 1992 payments.

Among the hospitals receiving special payments, rural referral centers are expected to benefit the most, receiving an average increase of 0.4 percent in their payments. However, rural disproportionate share hospitals with 100 or more beds may expect an average decrease in payments of 2.8 percent compared with current levels. This reduction is attributable primarily to a few hospitals in this category that were reclassified to an urban area in FY 1992 and received disproportionate share payments at the urban rate. Since these hospitals were not reclassified to urban areas for FY 1993, their payments fall dramatically.

The geographic analysis by census division shows that generally hospitals in urban areas are more likely than rural hospitals to receive a decrease in payments and hospitals located in rural areas are, on average, expected to receive an increase. However, there are notable exceptions in both groups. While urban hospitals in the West North Central and Mountain census divisions are projected to receive decreased payments of 0.3 percent, hospitals in the West South Central census division are expected to receive an average increase of 0.4 percent. Also, rural hospitals in the West South Central census division can expect an increase of 0.7 percent, which is the largest increase for the census divisions. However, our analysis shows that rural hospitals in the South Atlantic census division can expect average payment reductions of 0.7 percent, the largest decrease of any census division.

The foregoing analysis was based on MGCRB and HCFA Administrator decisions made by March 30 of this year. As previously noted, there will be changes to some MGCRB decisions through the appeals and review process. The outcome of these cases may affect the final results of our analysis, which we will present in the final rule.

2. Impact of Proposed Guideline Changes

Section 412.230(e) specifies the criteria a hospital must meet in order to be reclassified from one labor market to an adjacent one for purposes of the wage index. These criteria are based on average hourly wage differences between the two areas. As discussed in section IV of the preamble to this proposed rule, we are proposing an additional criterion that would require a hospital to demonstrate that its average hourly wage was at least 108 percent of the average hourly wage for hospitals in its current labor market area. The proposed guideline would be effective for applications filed by October 1, 1992 that are reviewed by the MGCRB in FY 1993. They would not affect payment until FY 1994.

Based on the FY 1993 reclassifications, we estimate that under the proposed change in the wage guideline, 75 percent of the hospitals that qualified for reclassification based on their wage index values would no longer qualify. This includes 79 percent of the urban hospitals and 62 percent of the rural hospitals that qualified in FY 1993. The following table shows the effect of the proposed change on the number of hospitals that would qualify for reclassification under the three reclassification categories and by urban

and rural geographic location.

DISTRIBUTION OF HOSPITALS BY RECLASSIFICATION STATUS

Reclassification status	Actual FY 1993 reclassification	Proposed change
All Hospitals.....	5394	5394
All Reclassified Hospitals.....	1196	526
Standardized Amount		
Only.....	96	247
Wage Index Only.....	912	242
Both.....	188	37
All Nonreclassified Hospitals.....	4148	4818
Hospitals Affected by Revised Guideline.....		759
Changed from Wage Index Only to No Reclassification.....		608
Changed from Both to Standardized Amount Only.....		151
All Reclassified Urban Hospitals.....	376	143
Standardized Amount		
Only.....	16	105
Wage Index Only.....	265	32
Both.....	95	6
All Nonreclassified Urban Hospitals.....	2502	2735
Urban Hospitals Affected by Revised Guideline.....		322
Changed from Wage Index Only to No Reclassification.....		233
Changed from Both to Standardized Amount Only.....		89
All Reclassified Rural Hospitals.....	820	383
Standardized Amount		
Only.....	80	142
Wage Index Only.....	647	210
Both.....	93	31
All Nonreclassified Rural Hospitals.....	1646	2083
Rural Hospitals Affected by Revised Guideline.....		437
Changed from Wage Index Only to No Reclassification.....		375
Changed from Both to Standardized Amount Only.....		62

For several reasons, it is difficult to estimate the impact the proposed changes would have on FY 1994 reclassifications (the year in which reclassifications based on the revised guidelines would take effect). Our estimates are based on the best data available. However, there are several policy changes that we anticipate will occur that will affect our estimates, but whose outcome cannot be predicted at this point. The following is a partial list of expected changes:

- The revised MSA definitions based on the 1990 Census data are expected to be effective for FY 1994 are likely to have a significant impact on hospital classifications. Until the new MSA definitions are released and hospitals

are regrouped based on these definitions, the impact on hospital reclassifications cannot be determined.

- As indicated in section IV.C of the preamble to this proposed rule, we are in the process of evaluating alternative methods for defining labor market areas and refinements could be implemented as early as FY 1994, the year in which reclassifications based on the revised guidelines would take effect. Any refinements to the labor market area definitions could significantly affect the impact of geographic reclassifications.

- Beginning in FY 1994, the wage data used to develop the wage index will be updated annually. This change, together with revised labor market areas, will affect the impact of FY 1994 wage index reclassifications and the number of hospitals that will qualify for reclassification beginning in FY 1995.

- Wage index reclassifications granted by the MGCRB also affect the geographic adjustment factor (GAF) applied to the capital prospective payment system rates. In addition, the level of the capital prospective payment rate is adjusted to account for any additional payments resulting from geographic reclassification. Therefore, a reduction in the number of reclassifications granted by the MGCRB as a result of changes in the guidelines would result in a corresponding increase in the capital prospective payment rate.

- Finally, beginning in FY 1995, the rural standardized payment amount will be eliminated. As a result, payments to rural hospitals will also be affected by the geographic reclassifications through the budget neutrality adjustment. That is, the standardized payment amount applicable to both urban and rural hospitals will be adjusted in order to finance the additional payments to hospitals that are reclassified by the MGCRB.

D. Effect of Changes in Outlier Payments (Columns 3A, B, and C)

1. Proposed Outlier Policy Changes

For computational reasons, we present in Table I, column 3A, the impact of increased FY 1993 outlier payments compared with estimated FY 1992 outlier payments before the impact of the proposed outlier policy changes, which are shown in column 3B. However, because of its significance, we discuss first the impact of the proposed outlier policy changes and then the impact of revisions to the outlier payment level.

Under current regulations at § 412.82(c), we compute the per diem DRG payment amount for day outlier

cases by dividing the adjusted DRG payment amount by the geometric mean length of stay for the DRG. We then multiply the per diem amount by a marginal cost factor of 60 percent times the number of days beyond the outlier threshold the patient remains in the hospital. As explained in section V.A.1. of the preamble to this proposed rule, the analysis conducted by the RAND Corporation shows that using the arithmetic mean length of stay in place of the geometric mean length of stay and a marginal cost factor of 55 percent instead of 60 percent results in more appropriate payments for day outlier cases and produces both a more equitable distribution of payments across outlier cases and payments that better protect hospitals from losses resulting from those cases.

Since we have made the aggregate effect of the change in outlier policy budget neutral, there is no overall effect on payments under the prospective payment system. Similarly, because there are separate outlier offsets to the urban and rural standardized amounts, there is no payment redistribution between urban and rural hospitals. Our analysis indicates that large hospitals (over 500 beds) located in urban areas would lose about 0.4 percent in payments per case. Also, hospitals located in large urban areas would be expected to receive a decrease in payments of 0.2 percent. On the other hand, urban hospitals with fewer than 100 beds would gain about 0.2 percent.

Among hospitals receiving special payments, hospitals with large teaching programs show a loss of 0.6 percent in payments per case. Also, hospitals that qualify as both sole community and rural referral centers are projected to lose about 0.2 percent in their payments per case. Payments to disproportionate share hospitals would be reduced by 0.3 percent.

When examined by census division, the effects are quite pronounced. Except for hospitals in the New England and Middle Atlantic divisions, we project increases in payments to urban hospitals of between 0.3 and 0.6 percent. Urban hospitals in the Middle Atlantic and New England census divisions would experience decreases in their payments of 1.3 and 0.3 percent, respectively. For rural hospitals, we find a similar though less dramatic pattern of redistributive effects. With the exception of the Middle Atlantic and South Atlantic divisions, the analysis shows increased payments ranging from 0 percent to 0.2 percent. The Middle Atlantic and South Atlantic census divisions are projected to receive

decreases in payments amounting to 0.7 and 0.1 percent, respectively.

In conclusion, the principal impact of the proposed changes in computing day outlier payments appears to be one of redistributing payments from hospitals in two of the census divisions to hospitals in the other census divisions, especially among hospitals located in urban areas.

2. FY 1992 Outlier Payments

Section 1886(d)(5)(A)(iv) of the Act requires that the total amount of additional payments made for outlier cases in a fiscal year may not be less than 5 percent nor more than 6 percent of the total prospective payments estimated to be made for discharges in that fiscal year. As described in the August 30, 1991 final rule (56 FR 43246), we established the thresholds for day and high cost outliers based on an estimate that outlier payments would equal 5.1 percent of total prospective payments. In addition, we reduced the standardized amounts by 5.1 percent for the estimated outliers payments. As the analysis in section V.A.4 of the preamble to this proposed rule describes, we now estimate that FY 1992 outlier payments will equal 3.6 percent of total DRG payments (exclusive of indirect teaching and disproportionate share payments) and 3.7 percent of total payments under the prospective payment system for operating costs. The average FY 1992 payment that we use in analyzing the impact of the proposed FY 1993 changes reflects the 3.6 percent outlier payment level. The outlier payment percentage in FY 1993 is estimated to be 5.1 percent. Ordinarily, we account for the difference between the estimated outlier payment percentage in the current year and the outlier payment percentage for the subsequent year in the All Changes column of Table I and indicate that we have done so in a footnote and a brief discussion in the text. However, given the magnitude of the difference between the estimated FY 1992 outlier payments and the 5.1 percent estimated for FY 1993, we are explicitly displaying the increase that will occur in total outlier payments in column 3A. This column reflects the additional outlier payments that we estimate will be made under current outlier policy compared to our estimate of FY 1992 outlier payments.

The effect of the difference between FY 1992 and FY 1993 estimated outlier payments would be to increase average payments per case, overall, by 1.6 percent. Among the hospital groupings, the effect is the greatest for those hospitals that receive a relatively high percentage of outlier payments. In terms

of geographic location, the effect would be larger for hospitals located in large urban areas—raising payments an average of 1.9 percent. The effect is smallest for rural hospitals—raising their payments by 0.7 percent. Among hospitals that receive additional payments or are grouped according to certain characteristics, hospitals with large teaching programs would receive the largest payment increases. The increase averages about 2.3 percent.

The analysis by census division shows urban hospitals in the Middle Atlantic census division receiving the greatest increase in payments. Urban hospitals would receive an average increase of 2.6 percent and rural hospitals would receive an average increase of 1.3 percent. Thus, in column 3C, we see that the net effect of the difference between FY 1992 and FY 1993 estimated payments and the proposed outlier policy changes is an increase in payments to hospitals in the Middle Atlantic census division of 1.3 percent for urban hospitals and 0.6 percent for rural hospitals, compared to FY 1992 payments.

E. Combined Effects of All Changes (Column 4)

In column 4 of Table I, we present the expected effects of all proposed changes for FY 1993 compared to expected payments under policies in effect for FY 1992. In addition to the changes being proposed for DRG weights (presented in column 1), the effects of FY 1993 geographic reclassification decisions (presented in column 2), and the changes to outlier payments (presented in columns 3A, B, and C), we incorporate the update factors being proposed for hospitals located in urban and rural areas (2.75 percent for urban hospitals and 3.75 percent for rural hospitals), the phase-out of the Medicare-dependent, small rural hospital provision, and revisions to the wage index and cost of living adjustments. Although we have not explicitly analyzed these changes in this impact analysis, they are discussed in the addendum to the proposed rule and in the preamble. As explained in our introductory remarks to the quantitative analysis section, some changes cannot be captured because we lack either current or complete data. There may also be interactive effects among the various factors comprising the payment system that we are not able to isolate. For these reasons, the values in column 4 may not equal the sum of the previous columns plus the other variables we are able to identify.

At the national level, our simulation of the proposed FY 1993 prospective

payment rates shows that the average payment to hospitals would increase 4.3 percent. Urban hospitals can expect an increase of 4.5 percent, with hospitals in the large urban areas receiving an increase of 4.5 percent and hospitals in the other urban areas receiving an increase of 4.6 percent. Hospitals in rural areas can expect an average increase in payments of 3.3 percent. The lower increase in rural hospital payments is attributable to the phase-out of the Medicare-dependent, small rural hospital provision and a smaller adjustment for FY 1992 outlier payment levels.

The analysis by census division shows that among urban hospitals, those in the West South Central census division are projected to receive an increase in payments per case of 5.6 percent, the largest increase of any census division. With the exceptions of hospitals in Puerto Rico, other projected increases range from 4.2 percent for hospitals in the Middle Atlantic division to 5.0 for the East South Central census division. Hospitals in Puerto Rico are projected to receive average increases of 3.7 percent.

Among the rural areas, the New England census division would receive the largest increase in payments per

case of 4.3 percent. The smallest increase is projected for the Middle Atlantic census division. Rural hospitals in that census division are projected to increase 2.0 percent.

Consistent with our expectations, reclassified hospitals would gain the most under the policies being proposed in this document. Hospitals that are being reclassified for the first time in FY 1993 would receive the largest payment gains of 8.3 percent, largely as a result of an increase of 4.1 percent directly attributable to their reclassification. In contrast, hospitals that were reclassified in FY 1992 and will be reclassified again in FY 1993 are projected to receive average payment increases of 3.4 percent, which is below the national average increase. Hospitals that were reclassified in FY 1992 but will not be reclassified in FY 1993 can expect average increases amounting to only 0.5 percent. Again, the small increase is due largely to the drop in payments of 3.6 percent as a result of these hospitals not being reclassified in FY 1993. Nonreclassified hospitals may expect increased payments amounting to about 4.2 percent.

Rural hospitals with fewer than 50 beds are projected to receive a payment increase of averaging 2.0 percent, and

hospitals with from 50 to 99 beds are projected to receive average increases of 2.8 percent. Both of these hospital groups are impacted adversely by the phase-out of the Medicare-dependent, small rural hospital provision. Overall, these two groups are estimated to experience payment reductions of 4.3 percent.

Rural, disproportionate share hospitals with 100 or more beds would receive an average increase of only 1.6 percent. As a group, proprietary hospitals are expected to receive a 4.9 percent increase. This represents the largest gain of any other group.

Table III presents the projected average payments per case under the changes proposed for FY 1993 for urban and rural hospitals and for the different categories of hospitals shown in Table I. It compares the projected payments with the average estimated per case payments that were effective October 1, 1991. Thus, this table presents, in terms of the average dollar amounts paid per discharge, the combined effects of the changes presented in Table I. That is, the percentage changes shown in the last column of Table I equal the percentage change in average payments from October 1, 1991 to October 1, 1992.

TABLE III—COMPARISON OF OPERATING PROSPECTIVE PAYMENTS PER CASE (FY 1992 PAYMENTS COMPARED TO PROPOSED FY 1993 PAYMENTS)

	Number of hospitals	Average FY 1992 payments/case	Average FY 1993 payments/case	All changes ¹
By Geographic Location				
All Hospitals	5,394	5,525	5,765	4.3
Large Urban Areas (populations over 1 million)	1,467	6,498	6,787	4.5
Other Urban Areas (populations of 1 million or fewer)	1,411	5,436	5,688	4.6
Rural Areas	2,516	3,839	3,965	3.3
Urban Hospitals				
0-99 beds	2,878	5,986	6,257	4.5
100-199 beds	670	4,245	4,415	4.0
200-299 beds	859	5,104	5,331	4.4
300-499 beds	614	5,544	5,801	4.6
500 or more beds	536	6,222	6,501	4.5
Rural Hospitals				
0-49 beds	199	7,692	8,049	4.6
50-99 beds	2,516	3,839	3,965	3.3
100-149 beds	1,239	3,197	3,262	2.0
150-199 beds	767	3,530	3,629	2.8
200 or more beds	264	3,970	4,110	3.5
Urban by Region				
New England	128	4,038	4,209	4.2
Middle Atlantic	116	4,633	4,811	3.8
South Atlantic				
East North Central				
East South Central				
West North Central				
West South Central				
Mountain				
Pacific				
Puerto Rico				
Rural by Region				
New England	172	6,327	6,598	4.3
Middle Atlantic	460	6,557	6,833	4.2
South Atlantic	418	5,687	5,964	4.9
East North Central	475	5,840	6,089	4.3
East South Central	168	5,187	5,444	5.0
West North Central	183	5,825	6,073	4.3
West South Central	352	5,433	5,738	5.6
Mountain	110	5,892	6,165	4.6
Pacific	492	6,781	7,076	4.4
Puerto Rico	48	2,286	2,371	3.7
Urban by Region				
New England	57	4,550	4,745	4.3
Middle Atlantic	93	4,224	4,368	2.0
South Atlantic	343	4,026	4,161	3.4
East North Central	346	3,859	3,981	3.2

TABLE III—COMPARISON OF OPERATING PROSPECTIVE PAYMENTS PER CASE (FY 1992 PAYMENTS COMPARED TO PROPOSED FY 1993 PAYMENTS)—Continued

	Number of hospitals	Average FY 1992 payments/case	Average FY 1993 payments/case	All changes ¹
East South Central	298	3,443	3,568	3.6
West North Central	564	3,557	3,647	2.5
West South Central	401	3,498	3,619	3.5
Mountain	241	4,093	4,259	4.1
Pacific	166	4,608	4,799	4.2
Puerto Rico	7	1,559	1,615	3.7
All Hospital	5,394	5,525	5,765	4.3
Large Urban Areas (populations over 1 million)	1,619	6,382	6,672	4.5
Other Urban Areas (populations of 1 million or fewer)	1,480	5,374	5,617	4.6
Rural Areas	2,295	3,793	3,909	3.1
Teaching Status				
Non-teaching	4,186	4,599	4,794	4.2
Resident/bed ratio				
Less than 0.25	968	5,949	6,212	4.4
Resident/bed ratio 0.25 or greater	239	9,297	9,717	4.5
Disproportionate Share Hospitals (DSH)				
Non-DSH	3,792	5,006	5,222	4.3
Urban DSH				
100 beds or more	1,133	6,650	6,947	4.5
Fewer than 100 beds	95	4,073	4,230	3.9
Rural DSH				
Sole community (SCH)	95	3,688	3,814	3.4
Referral centers (RRC)	44	4,489	4,657	3.7
Other rural DSH hospitals				
100 Beds or More	62	3,505	3,562	1.6
Fewer Than 100 beds	173	3,020	3,112	3.0
Urban Teaching and DSH				
Both Teaching and DSH	605	7,427	7,758	4.5
Teaching and No DSH	516	6,049	6,320	4.5
No Teaching and DSH	623	5,263	5,501	4.5
No Teaching and No DSH	1,355	4,879	5,110	4.7
Rural hospital Types				
Non Special Status Hospitals	1,010	3,366	3,482	3.5
RRC	179	4,401	4,591	4.3
SCH	532	3,849	4,006	4.1
Medicare-Dependent Hospitals (MDH)	515	3,323	3,182	-4.3
SCH and RRC	45	4,674	4,874	4.3
SCH or MDH	1,092	3,819	3,880	1.6
Hospitals Reclassified by the Medicare Geographic Classification Review Board				
Reclassification Status During FY 92 and FY 93				
Reclassified during both FY 92 and FY 93	847	4,868	5,032	3.4
Reclassified during FY 93 only	349	5,236	5,673	8.3
Reclassified during FY 92 only	82	4,502	4,526	0.5
FY 93 Reclassifications				
All Reclassified Hospitals	1,196	4,982	5,231	5.0
All Nonreclassified Hospitals	4,148	5,694	5,932	4.2
All Urban Reclassified Hospitals	376	5,800	6,128	5.7
Urban Nonreclassified Hospitals	2,502	6,018	6,279	4.3
All Reclassified Rural Hospitals	820	4,136	4,302	4.0
Rural Nonreclassified Hospitals	1,646	3,472	3,549	2.2
Other Reclassified Hospitals (Section 1886(D)(8)(B))	50	4,288	4,463	4.1
Type of Ownership				
Voluntary	3,188	5,670	5,915	4.3
Proprietary	749	5,134	5,384	4.9
Government	1,457	5,093	5,300	4.1
Medicare utilization as a percent of inpatient days				
0-25	277	7,141	7,471	4.6
25-50	1,934	6,098	6,375	4.6
50-65	2,213	4,986	5,201	4.3
Over 65	727	4,554	4,686	2.9

¹ Percentage changes shown in the column are taken from Table I, column 4. Because the dollar amounts shown in this table are rounded to the nearest whole dollar, percentage changes computed on the basis of these amounts will differ slightly from those presented in the last column of Table I.

VII. Impact of Changes in the Capital Prospective Payment System

A. General Considerations

Any impact analysis of payment changes for capital-related costs is limited by our ability to develop

meaningful projections of new capital investment. Our principal constraint is the lack of hospital-specific data on future hospital capital investments. The lack of hospital-specific data limits our impact analysis in the following ways:

- Major investment in hospital capital assets (for example in building and major fixed equipment) occurs at irregular intervals. As a result, there can be significant variation in the growth rates of Medicare capital-related costs per case among hospitals. We do not

have the necessary hospital-specific budget data to project the individual hospital capital growth rates. Since our projection of capital-related costs could be very inaccurate for individual hospitals, a cross-sectional impact analysis using the usual prospective payment system hospital groupings (for example, urban or rural, teaching or nonteaching, etc.) that rely on individual hospital projections from prior cost reports may not be representative of the impact of the FY 1993 proposed changes in the capital prospective payment system.

• Moreover, our policy of recognizing certain obligated capital as old capital complicates the problem of projecting future capital-related costs for individual hospitals. With the proposed changes we are making to § 412.302(c), a hospital will have until the later of October 1, 1992 or 90 days after the beginning of the hospital's first cost reporting period under the capital prospective payment system to notify its intermediary that it has obligated capital. The intermediary will have one year from the notification date to make its determination as to whether the obligated capital will qualify as old capital. Therefore, we will not know actual obligated capital commitments in time to be used in the FY 1993 capital cost projections. Without knowing what proportion of an individual hospital's future capital spending will qualify as old capital, we cannot accurately project how the hospital will be affected by the transition payment policies.

• A meaningful cross-sectional analysis of the capital prospective payment system would have to control for the two transitional payment methods implemented in the final rule (the hold-harmless method and the fully prospective payment methods) and accurately forecast FY 1993 asset acquisitions and disposals.

Because we will not have complete data reports from our payment systems and cannot accurately predict an individual hospital's FY 1993 capital-related costs, we cannot determine with any certainty the proportion of hospitals within a hospital grouping that will qualify for payment under the hold-harmless payment method or under the fully prospective payment method. A cross-sectional analysis that includes all hospitals without distinguishing between the payment methodologies and asset changes will not fully or

accurately present the redistributive effects that are expected to occur between "hold-harmless" hospitals and "fully prospective" hospitals. To present these effects, we use the results of our proposed FY 1993 actuarial model that distinguishes between high capital cost and low capital cost hospitals only. The cross-sectional analysis described later in this impact analysis is intended to provide only a sense of the distribution of the transition payment methodologies across hospital groupings from the provider-specific file used to make interim capital payments. We also present the effect of changes on the adjusted Federal rate across hospital groupings assuming payments were based on 100 percent of the Federal rate.

B. Projected Impact Based on the Proposed FY 1993 Actuarial Model

1. Assumptions

Based on the above considerations, our approach to the impact analysis in this proposed rule is similar to the approach we took in August 30, 1991 final rule (56 FR 43425). In the final rule, we used an actuarial model to project individual hospital capital growth rates for budget neutrality purposes and to estimate the impact of implementing the capital prospective payment methodology. In this impact analysis, we continue to model dynamically the impact of the capital prospective payment system from FY 1992 through FY 1993 using an actuarial model. The proposed FY 1993 actuarial model, described in Appendix B of this Federal Register document, integrates actual data from individual hospitals with randomly generated amounts developed from the results of the capital acquisition model used in the August 30, 1992 final rule. We have available more recent capital cost data from cost reports beginning in FY 1989 and FY 1990 through the Hospital Cost Reporting Information System (HCRIS), interim payment data for hospitals already receiving capital prospective payments through PRICER, and limited capital audit data from intermediary reports. However, we do not have individual hospital data on old capital changes, new capital formation, and obligated capital. Because we can combine actual data for individual hospitals with the results from the capital acquisition model, we need to generate only the old and new capital changes and obligated capital randomly.

All Federal rate payment parameters, which were randomly assigned by the capital acquisition model in the FY 1992 final rule, are assigned in the FY 1993 model to the applicable hospital.

For purposes of this impact analysis, the FY 1993 actuarial model includes the following assumptions:

• Medicare inpatient capital costs per discharge will increase at the following rates during these periods:

Fiscal year	Average percentage increase in capital costs per discharge
1992	9.10
1993	10.07

• The Medicare case mix index will increase by 2 percent annually.

• The Federal capital rate as well as the hospital-specific rate will be updated by the two year moving average increase in Medicare capital costs per case, net of case mix change increase, between FY 1988 and FY 1990. The FY 1993 update is 3.76 percent (see Addendum, Part III).

• Consistent with the budget neutrality constraints provided in section 4001(b) of Public Law 101-508, aggregate Medicare payments for capital costs in FY 1993 will equal 90 percent of total Medicare inpatient capital costs. The budget neutrality adjustment factor will be applied to the Federal and hospital-specific rates only and not to the hold-harmless payment for old capital.

2. Results

We have used the actuarial model to estimate the change in payment for capital-related costs from FY 1992 to FY 1993. To show the effect of the capital prospective payment system on low capital cost hospitals and high capital cost hospitals, we are presenting in Table IV the results of our simulation separately for low capital cost and high capital cost hospitals. We consider a hospital to be a low capital cost hospital if, based on a comparison of its initial hospital-specific rate and the applicable Federal rate, it will be paid under the fully prospective payment methodology. A high cost hospital is a hospital that, based on its initial hospital-specific rate, will be paid under the hold-harmless payment methodology. Based on our actuarial model, the breakdown of hospitals is as follows:

CAPITAL TRANSITION PAYMENT METHODOLOGY

Type of hospital	Percent of hospitals	FY 1993 percent of discharges	FY 1993 percent of capital costs	FY 1993 percent of capital payments
Low cost hospital.....	64	58	40	45
High cost hospital.....	36	42	60	55

A low cost hospital may request to have its hospital-specific rate redetermined based on old capital costs in the current year through the later of the hospital's cost reporting period beginning in FY 1994 or the first cost reporting period beginning after obligated capital comes into use. If the redetermined hospital-specific rate is

greater than the adjusted Federal rate, these hospitals will be paid under the hold-harmless payment methodology. Regardless of whether the hospital would become a hold-harmless payment hospital as a result of a redetermination in FY 1992 or FY 1993, we have continued to show these hospitals as low cost hospitals in Table IV. The

following table shows our estimate of the percentage of low capital cost hospitals that would be paid under the hold-harmless payment methodology through a hospital-specific rate redetermination and the basis of their payment under hold-harmless payment methodology:

Fiscal year	Percent of low cost fully prospective hospitals that qualify as hold-harmless	Of these, percent that are paid:	
		100% federal rate	Hold-harmless
1992.....	0.7	19	81
1993.....	0.7	5	95

Assuming no behavioral changes in capital expenditures, Table IV displays

the percentage in payments from FY 1992 to FY 1993 using the above

described actuarial model.

TABLE IV.—NPRM CAPITAL BUDGET NEUTRALITY FOR FY 1993-1995

[Impact of Proposed Changes for FY 1993 on Capital Payments per Discharge]

	No. of hospitals	Discharges	Adjusted Federal payment	Average Federal percent	Hospital specific payment	Hold-harmless payment	Exceptions payment	Total payment	Percent change
FY 1992 Payments Per Discharge									
Low Cost Hospitals.....	3,229	5,532,338	\$63.68	10.08	\$405.26	\$1.61	\$2.22	\$472.77	
Fully Prospective.....	2,975	5,253,721	63.60	10.00	410.11		1.99	475.71	
Rebase—Fully Prospective.....	233	257,167	55.36	10.00	340.08		6.20	401.64	
Rebase—100% Federal Rate.....	4	6,086	463.21	100.00				463.21	
Rebase—Hold Harmless.....	17	15,364	69.82	14.79		578.93	13.50	662.25	
High Cost Hospitals.....	1,828	3,997,419	326.13	50.15		464.79	19.59	810.50	
100% Federal Rate.....	659	1,618,627	671.59	100.00			37.79	709.38	
Hold Harmless.....	1,169	2,378,792	91.07	14.32		781.05	7.20	879.31	
Total Hospitals.....	5,057	9,529,757	173.77	27.18	235.27	195.90	9.50	614.44	
FY 1993 Payments Per Discharge									
Low Cost Hospitals.....	3,229	5,532,338	131.88	20.04	371.83	1.99	6.68	512.39	8.38
Fully Prospective.....	2,975	5,253,721	132.55	20.00	376.28		5.36	514.19	8.09
Rebase—Fully Prospective.....	233	257,167	115.32	20.00	311.92		33.43	460.67	14.70
Rebase—100% Federal Rate.....	1	820	391.02	100.00				391.02	-15.59
Rebase—Hold Harmless.....	20	20,630	156.83	30.65		534.81	10.65	702.30	6.05
High Cost Hospitals.....	1,828	3,997,419	396.64	57.63		434.80	35.12	868.57	6.92
100% Federal Rate.....	703	1,713,592	700.60	100.00			54.25	754.85	6.41
Hold Harmless.....	1,125	2,283,827	168.58	24.83		761.04	20.77	950.39	8.08
Total Hospitals.....	5,057	9,529,757	242.94	36.22	215.86	183.54	18.61	660.95	7.57

Under section 1886(g)(1) of the Act, aggregate payments under the capital prospective payment system for FY 1992 through 1995 are to equal 90 percent of what would have been payable on a reasonable cost basis in each year, respectively. (See Addendum, Part III for

a full discussion of the budget neutrality provision.) We project that in FY 1992 aggregate payments under the capital prospective payment system are 2.1 percent higher than 90 percent of reasonable costs. To achieve budget neutrality in FY 1993, we estimate there

would be an aggregate 7.6 percent increase in Medicare capital payments over the FY 1992 payments.

We project that low capital cost hospitals paid under the fully prospective payment methodology will experience an average case-weighted

increase in payments of 8.4 percent, and high capital cost hospitals will experience an average increase of 6.9 percent.

For hospitals paid under the fully prospective payment methodology, the Federal rate payment percentage will increase from 10 percent to 20 percent and the hospital-specific rate payment percentage will decrease from 90 to 80 percent in FY 1993.

The Federal rate payment percentage for a hospital paid under the hold-harmless payment methodology is based on the hospital's ratio of new capital costs to total capital costs. The average Federal rate payment percentage for those hospitals receiving a hold-harmless payment for old capital will increase from 14.3 percent to 24.8 percent. We estimate the percentage of hold-harmless hospitals paid based on 100 percent of the Federal rate will increase from 36 to 38 percent.

We are proposing no changes in our exceptions policies in FY 1993. As a result, the minimum payment levels would be:

- 90 percent for sole community hospitals;

- 80 percent for urban hospitals with 100 or beds and a disproportionate share patient percentage of 20.2 percent or more; or,

- 70 percent for all other hospitals.

We estimate that there will be a 96 percent increase in exceptions payments in FY 1993. The projected distribution of the payments is shown in the table below:

ESTIMATED FY 1993 EXCEPTIONS PAYMENTS

Type of hospital	No. of hospitals	Percent of exceptions payments
Low Capital Cost	204	20.8
High Capital Cost	316	79.2
Total	520	100.0

C. Cross-Sectional Comparison of Capital Prospective Payment Methodologies

1. Introduction

Table V presents a cross-sectional summary of hospital by capital prospective payment methodology. This

distribution is not generated by our actuarial model. Rather, it is based on the December 31, 1991 update of the Provider-Specific File used by intermediaries to make interim capital payments using the PRICER program. The payment methodology distribution is based on 2,477 hospitals for which capital data are available on file. It is important to note in reviewing the data presented in Table V that we have interim capital payment data from our Hospital Specific File for only 44 percent of the hospitals. The data are not fully representative of the payment methodologies that will be applicable to the full set of hospitals. For example, the reporting cycle for the higher capital intensity teaching hospital group is generally later in the Federal fiscal year and would be expected to alter the proportions of hospitals in the categories shown. These hospital groups should be more adequately represented in the impact analysis presented in the final rule.

TABLE V.—DISTRIBUTION BY METHOD OF PAYMENT (HOLD-HARMLESS/FULLY PROSPECTIVE) OF HOSPITALS RECEIVING CAPITAL PAYMENTS

	(1) Total No. of hospitals	(2) No. of hospitals reporting	(3) Hold-harmless		(4) Percentage paid fully prospective rate
			Percentage paid hold- harmless (A)	Percentage paid fully federal (B)	
By Geographic Location					
All hospitals.....	5,394	2,477	17.2	13.3	69.5
Large urban areas (populations over 1 million).....	1,467	677	23.5	17.4	59.1
Other urban areas (populations of 1 million or fewer).....	1,411	589	20.9	19.9	59.3
Rural areas.....	2,516	1,211	12.0	7.8	80.3
Urban hospitals.....	2,878	1,266	22.3	18.6	59.2
0-99 beds.....	670	286	17.8	18.2	64.0
100-199 beds.....	859	391	26.9	20.5	52.7
200-299 beds.....	614	291	23.0	18.2	58.8
300-499 beds.....	536	218	20.6	17.0	62.4
500 or more beds.....	199	80	17.5	16.3	66.3
Rural hospitals.....	2,516	1,211	12.0	7.8	80.3
0-49 beds.....	1,239	594	7.4	4.4	88.2
50-99 beds.....	767	364	14.6	9.6	75.8
100-149 beds.....	264	132	20.5	12.1	67.4
150-199 beds.....	128	62	16.1	11.3	72.6
200 or more beds.....	116	58	19.0	17.2	63.8
By Region					
Urban By Region:					
New England.....	172	138	10.9	13.8	75.4
Middle Atlantic.....	460	95	21.1	17.9	61.1
South Atlantic.....	418	137	29.2	18.2	52.6
East North Central.....	475	286	11.2	25.2	63.6
East South Central.....	168	39	43.6	10.3	46.2
West North Central.....	183	121	18.2	14.9	66.9
West South Central.....	352	133	49.6	24.8	25.6
Mountain.....	110	60	26.7	15.0	58.3
Pacific.....	492	233	20.2	16.3	63.5
Puerto Rico.....	48	24	29.2	0.0	70.8
Rural By Region:					
New England.....	57	33	6.1	12.1	81.8

TABLE V.—DISTRIBUTION BY METHOD OF PAYMENT (HOLD-HARMLESS/FULLY PROSPECTIVE) OF HOSPITALS RECEIVING CAPITAL PAYMENTS—Continued

	(1) Total No. of hospitals	(2) No. of hospitals reporting	(3) Hold-harmless		(4) Percentage paid fully prospective rate
			Percentage paid hold- harmless (A)	Percentage paid fully federal (B)	
Middle Atlantic.....	93	1	0.0	0.0	100.0
South Atlantic.....	343	182	18.7	9.3	72.0
East North Central.....	346	182	7.7	12.1	80.2
East South Central.....	298	134	14.9	9.0	76.1
West North Central.....	564	273	5.1	2.6	92.3
West South Central.....	401	159	21.4	13.2	65.4
Mountain.....	241	178	12.9	3.9	83.1
Pacific.....	166	68	5.9	5.9	88.2
Puerto Rico.....	7	1	0.0	0.0	100.0
By Payment Classification					
All Hospitals.....	5,394	2,477	17.2	13.3	69.5
Large urban areas (populations over 1 million).....	1,619	775	22.7	18.5	58.8
Other urban areas (populations of 1 million or fewer).....	1,480	609	21.0	17.7	61.2
Rural areas.....	2,295	1,093	11.3	7.1	81.6
Teaching status:					
Non-teaching.....	4,186	1,968	18.1	12.5	69.4
Resident/bed ratio less than 0.25.....	968	427	14.8	15.5	69.8
Resident/bed ratio 0.25 or greater.....	239	81	9.9	21.0	69.1
Disproportionate share hospitals (DSH).....					
Non-DSH rural.....	2,295	1,093	11.3	7.1	81.6
Non-DSH urban.....	852	376	18.6	17.3	64.1
Urban DSH, 100 beds or more.....	2,247	1,008	23.2	18.5	58.3
Rural Hospital Types:					
Non special status hospitals.....	1,010	468	9.6	8.8	81.6
RRC.....	179	88	20.5	17.0	62.5
SCH.....	532	282	13.5	4.3	82.3
Medicare-dependent hospitals (MDH).....	515	226	6.6	3.1	90.3
SCH and RRC.....	45	22	22.7	9.1	68.2
SCH or MDH.....	1,092	530	10.9	4.0	85.1
Type of Ownership					
Voluntary.....	3,188	1,528	16.2	15.2	68.6
Proprietary.....	749	251	42.6	18.3	39.0
Government.....	1,457	698	10.3	7.3	82.4
Medicare Utilization as a Percent of Inpatient Days:					
0-25.....	277	119	20.2	14.3	65.5
25-50.....	1,934	951	18.2	15.6	66.2
50-65.....	2,213	1,030	16.9	11.6	71.6
Over 65.....	727	295	13.2	8.5	78.3

In Table V, we are presenting the distribution of the capital payment methodologies for teaching hospitals in terms of the resident-to-bed ratio specifically so that readers may compare these analyses with those for the prospective payment system for operating costs. Also, we have not yet developed a break point for distinguishing heavy teaching involvement from light teaching involvement using the resident-to-average-daily-census ratio that is comparable to the break point developed for the resident-to-bed ratio (resident-to-bed ratios less than .25 or ratios equal to or greater than .25). Although we are classifying teaching hospitals according to their resident-to-bed ratio for display purposes, for our Federal rate payment simulations, we have computed the indirect medical education adjustment factor using the ratio of resident-to-average-daily-census.

2. Distribution of Hospitals by Payment Methodology

The cross-sectional distribution of hospital by payment methodology is provided by: (1) Geographic location, (2) region, and (3) payment classification. This provides an indication of what percentage of hospitals within a particular hospital groupings will be paid under the fully prospective payment methodology and under the hold-harmless methodology. The information is based on the 2,477 hospitals with interim capital payment data on the December 31, 1991 Provider Specific File. Since the data are based on 44 percent of hospitals, the distribution does not match the projections in our actuarial model. We expect that as additional hospitals become subject to the capital prospective payment system later in FY 1992, the percentage of hospitals paid

under the hold-harmless methodology will increase from 30 to 36 percent.

The distribution of hospitals by capital payment methodology is generally consistent with the distribution of low and high capital cost hospitals in the August 30, 1992 final rule. As expected, a relatively higher percentage of rural and governmental hospitals are being paid on the fully prospective payment methodology. This is a reflection of their lower than average capital costs per case. More than 80 percent of these hospitals would be paid under the fully prospective payment methodology compared to an average of 60 percent of hospitals with reported data. In contrast, only 39 percent of the proprietary hospitals with reported data are being paid under the fully prospective payment methodology. This is the only group of hospitals that is expected to have a majority of hospitals paid under the hold harmless methodology. As we noted in the August

30, 1991 final regulations (56 FR 43430), we found that about 62.7 percent of proprietary hospitals have a capital cost per case above the national average cost per case.

3. Federal Rate Payment Simulations.

To estimate the potential impact of our proposed changes for FY 1993 on payments based solely on the Federal rate, we simulated payments under the FY 1992 Federal rate and our proposed FY 1993 Federal rate using a universe of 5,394 hospitals. The individual hospital payment parameters are taken from the best available data, including: FY 1991 MEDPAR bills, the December 31, 1991 update to the Provider-Specific File, and cost report data for cost reporting periods beginning in FY 1990. Table VI presents a comparison of payments per case for FY 1992 and FY 1993 based on 100 percent of the Federal rate. The comparisons are provided by: (1) Geographic location, (2) payment classification, and (3) payment region.

The simulation results show that, on average, Federal rate payments per case, exclusive of any change in the Federal rate payment percentage, can be expected to increase by 2.0 percent. This increase results from the combined effects of: (1) The proposed 3.76 percent annual update, (2) a 1.7 percent increase due to the change in the outlier offset and the increase in outlier payments, (3) a 1.0 percent decrease due to the budget neutrality reduction for changes in the wage index and DRG weights, (4) a 2.07

percent decrease for exceptions, and (5) a 0.4 percent increase in the budget neutrality reduction.

The distributional effects of the changes in Federal rate payments primarily result from DRG recalibration, changes in the geographic adjustment factor (including both wage index corrections and geographic reclassifications), and changes in the outlier payment policy. The increase in payments per case will be larger for urban hospitals (2.1 percent) than for rural hospitals (1.4 percent). We believe that this difference is due to the fact that the increase in outlier payments relative to FY 1992 outlier payments and the DRG classification changes have a predominantly urban effect.

Sole community hospitals realize a smaller increase (0.5 percent) than any other payment classification. This is probably due to the fact that they will realize a smaller gain from the increase in the outlier payments compared to FY 1992 levels because they tend to have fewer outlier cases.

Section 1886(d)(10) of the Act established the Medicare Geographic Classification Review board (MGCRB). Fiscal year 1992 is the first year that hospitals were reclassified as a result of decisions by the MGCRB. Hospitals may apply for reclassification for the purpose of obtaining a higher wage index value, standardized payment amount or both a higher standardized payment amount and wage index value. Although there is no difference with respect to the Federal

capital rate, a hospital's geographic classification for purposes of the operating standardized amount does affect a hospital's capital payments as result of the large urban adjustment factor. Reclassification for wage index purposes affects the geographic adjustment factor since it is constructed from the hospital wage index.

To present the effects of the hospitals being reclassified for FY 1993 compared to FY 1992, we show the average Federal Rate payment percentage increase for hospitals reclassified in each fiscal year and in total. For FY 1993

reclassifications, we are indicating those hospitals reclassified for standardized amount purposes only, for wage index purposes only and for both factors. The reclassified groups are compared to all other nonreclassified hospitals. These categories are further identified by urban and rural designation.

Hospitals reclassified by the Medicare Geographic Classification Board during FY 1993 only can be expected to realize a much larger increase (5.5 percent) than other hospitals. Similarly, hospitals reclassified during FY 1992 only do much worse in FY 1993 (a 0.9 percent decrease) than other hospitals as they lose the higher payments from their geographic reclassification during FY 1992.

By region, the significantly greater gain of urban hospitals in the West South Central region (3.5 percent increase) is probably due to geographic reclassifications.

TABLE VI—COMPARISON OF FEDERAL RATE PAYMENTS PER CASE
[FY 1992 Payments Compared to Proposed FY 1993 Payments Based on 100% Federal Rate]

	Number of hospitals	Average FY 1992 payments/case	Average FY 1993 payments/case	All changes
By Geographic Location:				
All Hospitals.....	5,394	631	644	2.0
Large Urban Areas (populations over 1 million).....	1,467	735	750	2.0
Other Urban Areas (populations of 1 million or fewer).....	1,411	625	638	2.2
Rural Areas.....	2,516	447	454	1.4
Urban Hospitals.....	2,878	682	696	2.1
0-99 Beds.....	670	503	512	1.8
100-199 Beds.....	859	596	609	2.2
200-299 Beds.....	614	644	658	2.2
300-499 Beds.....	536	708	722	1.9
500 or more Beds.....	199	838	856	2.1
Unknown.....	0	0	0	0.0
Rural Hospitals.....	2,516	447	454	1.4
0-49 Beds.....	1,239	375	377	0.6
50-99 Beds.....	767	416	420	1.1
100-149 Beds.....	264	465	472	1.5
150-199 Beds.....	128	472	480	1.7
200 or more Beds.....	116	528	539	2.0
Unknown.....	2	564	574	1.7
Urban by Region:				
New England.....	172	711	721	1.4
Middle Atlantic.....	460	731	734	1.7
South Atlantic.....	418	656	673	2.7
East North Central.....	475	665	676	1.7
East South Central.....	168	593	609	2.7

TABLE VI—COMPARISON OF FEDERAL RATE PAYMENTS PER CASE—Continued

[FY 1992 Payments Compared to Proposed FY 1993 Payments Based on 100% Federal Rate]

	Number of hospitals	Average FY 1992 payments/case	Average FY 1993 payments/case	All changes
West North Central.....	183	675	687	1.7
West South Central.....	352	628	650	3.6
Mountain.....	110	688	704	2.3
Pacific.....	492	772	786	1.7
Puerto Rico.....	48	275	280	1.5
Rural by Region.....				
New England.....	57	519	523	0.8
Middle Atlantic.....	93	492	496	0.8
South Atlantic.....	343	469	478	1.8
East North Central.....	346	451	457	1.3
East South Central.....	298	404	409	1.1
West North Central.....	564	416	422	1.3
West South Central.....	401	412	419	1.7
Mountain.....	241	465	470	1.0
Pacific.....	166	536	544	1.5
Puerto Rico.....	7	220	221	0.5
By Payment classification:				
All Hospitals.....	5,394	631	644	2.0
Large Urban Areas (populations over 1 million).....	1,619	724	739	2.0
Other Urban Areas (populations of 1 million or fewer).....	1,480	617	630	2.1
Rural Areas.....	2,295	441	447	1.3
Teaching Status:				
Non-Teaching.....	4,186	543	554	2.0
Resident/Bed Ratio less than 0.25.....	968	681	693	1.9
Resident/Bed Ratio 0.25 or greater.....	239	962	982	2.1
Disproportionate share hospitals (DSH):				
Non-DSH Rural.....	2,295	441	447	1.3
Non-DSH Urban.....	852	496	504	1.7
Urban DSH 100 Beds or more.....	2,247	689	704	2.1
Rural Hospital Types:				
Non Special Status Hospitals.....	1,010	412	417	1.2
RRC.....	179	508	518	1.8
SCH.....	532	422	426	0.8
Medical-Department Hospitals (MDH).....	515	376	379	0.9
SCH and RRC.....	45	514	522	1.5
SCH or MDH.....	1,092	423	427	1.0
Hospitals reclassified by the Medicare Geographic Classification Review Board:				
Reclassification Status During FY92 and FY93:				
Reclassification during both FY92 and FY93.....	847	565	571	1.0
Reclassification during FY93 only.....	349	605	639	5.6
Reclassification during FY92 only.....	82	514	509	-0.9
FY93 Reclassifications:				
All reclassified Hospitals.....	1,196	578	592	2.5
All nonreclassified hospitals.....	4,148	648	660	1.8
All Urban reclassified Hospitals.....	376	668	688	3.0
Urban nonreclassified Hospitals.....	2,502	684	697	1.9
All reclassified Rural Hospitals.....	820	484	493	1.8
Rural nonreclassified Hospitals.....	1,646	401	404	0.7
Other reclassified Hospitals (section 1886(D)(8)(B)).....	50	512	521	1.7
Type of ownership:				
Voluntary.....	3,188	649	661	1.9
Proprietary.....	749	603	620	2.9
Government.....	1,457	565	575	1.8
Medicare utilization as a percent of Inpatient Days:				
0-25.....	277	747	760	1.8
25-50.....	1,934	687	701	2.1
50-65.....	2,213	583	594	1.9
Over 65.....	727	539	548	1.7

Appendix B: Description of the Capital Acquisition Model and Budget Neutrality Adjustment

Section 1886(g)(1) of the Act (as amended by section 4001 of Pub. L. 101-508) requires that for FY 1992 through FY 1995 aggregate prospective payments for operating costs under section 1886(d) and prospective payments for capital costs under section 1886(g)(1) of the Act be reduced each year in a manner that

results in savings equal to 10 percent of the amount that would have been payable on a reasonable cost basis for capital-related costs in that year. Under § 412.352, the 10 percent savings is generated entirely from the capital prospective payments. A budget neutrality adjustment factor is applied to the Federal rate and hospital-specific rate so that total capital payments for FY 1992 through FY 1995 approximately

equal 90 percent of Medicare inpatient capital costs in each year.

To calculate budget neutrality, the hold-harmless provision of the payment methodology requires that we identify old and new capital; that is, we must be able to project the rate at which old capital will be depreciated and written off and at which new capital will be acquired and depreciated. (Old capital costs are depreciation, lease, interest

expenses, and other capital-related costs defined in § 412.302 that are in use or obligated on or before December 31, 1990.)

In developing the FY 1992 prospective payment rates, there was limited capital data available that could be used to project payments under the capital prospective payment system and develop the budget neutrality adjustment factor. Consequently, we developed a capital acquisition model that relied on Monte Carlo random simulation techniques to project capital costs for 6000 hypothetical hospitals. This model is described in detail in the August 30, 1991 final rule (56 FR 43517-43522). The model will be referred to as the capital acquisition model in the following discussion.

Since publication of the August 31, 1991 final rule, capital data have become available that can be incorporated directly into the determination of budget neutrality. The available data include: the December 31, 1991 update of the Hospital-Specific File that provides the data items needed by the PRICER program used by the intermediaries to determine interim payments to hospitals; cost reports for cost reporting periods beginning in FY 1989 (PPS-6) that overlap the base year for determining the hospital-specific rate; and, data reported by the intermediaries that includes the hospital-specific rate determinations that have been made through February 1992. The December 31, 1991 update to the Provider-Specific File contains data on interim payments under the capital prospective payment system for approximately 44 percent of all hospitals. Generally, the data are for hospitals that became subject to the capital prospective payment system effective with their cost reporting period beginning on or before January 1, 1992.

The available data sources directly supply, or can be used to calculate, the hospital-specific rate. For those hospitals with capital data on the Provider-Specific File, the payment methodology as well as the estimated FY 1992 hold-harmless amount and new capital ratio for hospitals paid under the hold-harmless payment methodology is also available.

The available data still lack certain items which are required for the determination of budget neutrality. These items are the hospital's new capital costs for each year, its old capital costs for each year, and the obligated capital amounts for assets that will be put in use for patient care services and recognized as old capital each year.

For FY 1993, we are proposing to use an integrated model that starts with the

available data for existing hospitals and back-fills the missing items with results from the capital acquisition model that was used to develop the FY 1992 payment rates. Since hospitals under alternative payment system waivers are currently excluded from the capital prospective payment system, we excluded these hospitals (hospitals in Maryland and hospitals in the Finger Lakes Area Hospital Corporation in New York) from our proposed model.

We have not modified the parameters of the FY 1992 capital acquisition model; however, we analyzed several capital growth patterns generated by that model to backfill the elements for which actual data are not available. These patterns include the distribution of growth rates in old capital (exclusive of obligated capital), the new capital ratio (which includes obligated capital), and the ratio of obligated capital costs for assets being put in use for patient care to total capital costs. In all cases, the distributions from the model were fitted to the beta distribution. The beta distribution is a two parameter distribution with the range restricted from zero to one. The growth rate for old capital (which is exclusive of obligated capital) must be between zero and one since depreciation and interest on old capital cannot increase. The ratio of new capital to total capital and the ratio of obligated capital to total capital are necessarily between zero and one. Hence, the beta distribution is ideal for this purpose, especially since the two parameters provide a range of shapes.

With regard to the new capital ratio for years after FY 1992, the model fits the change in the ratio from one year to the next to the beta distribution. This is to prevent large swings in the new capital ratio over time. It is possible to have a decrease in the new capital ratio since some new capital may have a short useful life compared to old capital. Therefore, we rescaled the range of the changes in the ratios since the beta distribution must have numbers between zero and one.

The proposed model first develops the hospital-specific rate. Where available, this rate is taken from the December 1991 update of the Provider-Specific File. This file contains the actual amounts used by the intermediaries with the PRICER program to compute interim capital prospective payments. If the hospital-specific rate is not available from the Provider-Specific File, the second source is the audit information reported by the intermediaries. If this is not available, the model computes the hospital-specific rate from the hospital's cost reporting period beginning in FY

1990 as reported on the HCRIS as of December 1991 update.

The proposed model also develops the old capital amount for each hospital. If available, the model uses the hold-harmless payment per discharge from the Provider-Specific File. If the actual hold-harmless amount is not available, the model develops an estimate from the hospital's hospital-specific rate. It computes an FY 1990 capital cost per discharge by dividing the 1992 hospital-specific rate by factors used to inflate base year capital cost per discharge to FY 1992 as set forth in the August 30, 1991 final rule (56 FR 43390). The model updates the base year capital per discharge to FY 1992 using a two-year rate of increase (FY 1990 to FY 1992) in old capital that is randomly generated from the beta distribution described above. This old capital amount for FY 1992 excludes any obligated capital that has been put in use since the base year. Excluding obligated capital from the old capital growth factors produces a more stable growth sequence with lower variance. The development of the hospital's obligated capital costs is described below. Before we update the hospital's old capital costs in a given year, the model adds the obligated capital that is first depreciated in the current year to the old capital cost for that year. As a result, any obligated capital depreciation and interest expense projected by the model is incorporated into the hospital's old capital costs in subsequent years.

The proposed model also develops the new capital ratio for each hospital. If available, the model uses the hospital's new capital ratio from the Provider-Specific File. If the actual new capital ratio is not available, the model generates the ratio from a beta distribution as described above. For purposes of fitting the new capital ratio to the beta distribution, the model treats obligated capital as new capital. The model restricts the new capital ratio to 90 percent in all cases. After fitting the FY 1992 new capital ratio, the year-to-year change in the new capital ratio is fit to the beta distribution. The new capital ratio combined with the old capital amount generates the total capital costs.

Finally, the model develops the obligated capital ratio for obligations first being depreciated in the year under analysis. It generates an obligated capital ratio using a beta distribution fitted to the results of the capital acquisition model (and obligation capital assumptions) as described above. This ratio is an offset to the new capital ratio. Consequently, the

obligated capital ratio is restricted to the magnitude of the new capital ratio. The new capital ratio is reduced by the obligated capital ratio.

If a hospital has a hold-harmless payment amount available on the Hospital-Specific File, this amount includes the effect of obligated capital on its FY 1992 old capital costs per discharge. Therefore, the model does not generate any additional FY 1992 obligated capital for these hospitals. We necessarily generated obligated capital amounts for all hospitals for FY 1993 and later.

The model does not recompute the hospital's total capital costs for obligated capital. Instead, obligated capital costs are the product of the obligated capital ratio and total capital costs. The hospital's costs for new capital are the product of the revised new capital ratio times the hospital's total capital costs.

We computed the average total capitals cost per discharge from the capital costs that were generated by the model and compared the results to total capital costs per discharge that we had projected independently of the proposed model. The capital amount in any year is composed of capital previously acquired (old capital) and capital acquired in the current year (new capital and new obligated capital). We cannot adjust the old capital component since it is a function of acquisitions in earlier years. Consequently we can only adjust new and obligated capital amounts. We proportionately adjusted the new and obligated capital amounts so that the total capital costs per discharge generated by the model match the independently projected capital costs per discharge.

To summarize, the proposed model integrates actual data with randomly generated amounts developed from the results of the capital acquisition model. We generated at most three numbers for each hospital each year. Only the old capital increase, new capital ratio, and obligated capital ratio are randomly generated.

Once each hospital's capital-related costs are generated, the model projects capital payments. In FY 1992, we randomly generated all payment parameters (for example, the case-mix index and the geographic adjustment factor). In the proposed model, we use the actual payment parameters that are applicable to the specific hospital.

To project capital payments, the proposed model first assigns the applicable payment methodology (fully prospective or hold-harmless) to the hospital. If available, the model uses the payment methodology method indicated

in the Provider-Specific File. Otherwise, the model determines the methodology by comparing the hospital's hospital-specific rate to the adjusted Federal rate applicable to the hospital. The model simulates Federal rate payments using the assigned payment parameters and hospital-specific estimated outlier payments. The case-mix index for a hospital is derived from the 1991 MEDPAR file using the proposed FY 1993 DRGs and relative weights. The case-mix index is increased 2 percent per year after FY 1991 consistent with the continuing trend (which we expect to continue) in case-mix increase.

Changes in geographic reclassification and corrections in the hospital wage data used to establish the hospital wage index affect the geographic adjustment factor, and changes in the DRG classification system and the relative weights affect the case mix index. Section 412.308(c)(4)(ii) requires that the estimated aggregate payments for the fiscal year based on the Federal rate after any changes resulting from changes in the DRG classification system and relative weights and in the geographic adjustment factor equal the estimated aggregate payments, payments based on the Federal rate that would have been made without such changes. To determine the budget neutrality adjustment factor needed to make the effect of the DRG and geographic adjustment changes budget neutral on estimated Federal rate payments, we first determined the portion of the Federal rate that would be paid for each hospital in FY 1993 based on its applicable payment methodology. We then compared what aggregate Federal rate payments would be based on the FY 1992 DRG relative weights and geographic adjustment factor to aggregate Federal rate payments based on the FY 1993 relative weights and geographic adjustment factor. In making the comparison, we held the FY 1993 Federal rate portion constant and set the other budget neutrality adjustment factor and exceptions reduction factor to 1.00. We determined that to achieve budget neutrality for the changes in the geographic adjustment factor and the DRG weights, a budget neutrality adjustment factor of 0.9906 should be applied to the FY 1993 Federal rate.

The methodology used to determine the geographic and recalibration budget neutrality adjustment factor is similar to that used in establishing budget neutrality adjustments under the prospective payment system for operating costs. One difference is that under the operating prospective payment system, the budget neutrality adjustments for the effect of geographic

reclassifications are determined separately from the effects of other changes in the hospital wage index and the DRG weights. Under the capital prospective payment system, there is a single budget neutrality adjustment factor for changes in the geographic adjustment factor (including geographic reclassification change since FY 1992) and the DRG relative weights. In addition, there is no adjustment for the effects that geographic reclassification has on the other payment parameters, such as the payments for serving low-income patients or the large urban add-on.

In addition to computing the geographic and recalibration budget neutrality adjustment factor, we used the proposed model to project total aggregate payments under the prospective payment system and to compute the budget neutrality adjustment factor that would result in estimated payments under the capital prospective payment system equal 90 percent of what would have been payable on a reasonable cost basis. This budget neutrality factor is applied to the Federal and hospital-specific rates, but not to the hold-harmless payments.

Additional payments under the exceptions process are financed through a reduction in the Federal and hospital-specific rates. Therefore, we used the proposed model to calculate estimated exceptions payments and the exceptions reduction factor. This exceptions reduction factor ensures that estimated aggregate payments under the capital prospective payment system, including exceptions payments, equal what aggregate payments would be under the capital prospective payment system without an exceptions process. Since changes in the level of the payment rates change the level of payments under the exceptions process, the budget neutrality and exceptions adjustments factors must be determined through iteration. Further, these two factors interact with each other so that they must be determined simultaneously. We successfully determined values for these factors so that the exceptions adjustment factor is correct and estimated payments under the capital prospective payment system equal 90 percent of estimate Medicare inpatient capital costs.

In the August 30, 1991 final rule, we indicated that we would publish each year the estimated payment factors generated by the model to determine payments for the next five years. The table below provides the actual FY 1992 factors, the proposed FY 1993 factors, and the estimated factors that would be

applicable through FY 1997. We caution that, except with respect to FY 1992 and FY 1993, these are estimates only and

are subject to revisions resulting from continued methodological refinements, more recent data, and any payment

policy changes that may occur. The projections are as follows:

Fiscal year	Increase in cost per discharge	Update factor	Exceptions reduction factor	Budget neutrality factor	Federal rate (after outlier reduction)
1992	6.96	N/A	.9813	.9602	415.59
1993	7.91	3.76	.9610	.9564	416.36
1994	8.91	6.19	.9249	.9786	435.40
1995	8.77	5.99	.9000	.9993	458.56
1996	8.73	7.44	.9000	N/A	493.02
1997	8.71	8.41	.9000	N/A	534.48

¹ Note: Adjusted for estimated 2.0 percent increase in case-mix index.

Appendix C—Letters to Congress

March 30, 1992.

The Honorable Dan Quayle,
President of the Senate, Washington, D.C.
20510

Dear Mr. President: Section 1886(e)(3)(B) of the Social Security Act requires that the Secretary of Health and Human Services, not later than March 1, 1992, report to the Congress his initial estimate of the applicable percentage increase in payments for inpatient operating costs for FY 1993 that he will recommend for hospitals subject to the Medicare prospective payment system (PPS) and for excluded hospitals and units. This submission constitutes the required report.

President Bush's budget incorporates updates consistent with those mandated by current law. The budget recommends an update for hospitals subject to the PPS equal to the rate of increase in the hospital market basket minus 1.55 percentage points for urban hospitals and the rate of increase in the hospital market basket minus 0.55 percentage points for rural hospitals. For hospitals excluded from the PPS, the budget includes an average increase in the Tax Equity and Fiscal Responsibility Act limit equal to the rate of increase in the hospital market basket. In addition, the budget contains a legislative proposal to move the annual update for hospitals from October 1 to January 1 to conform with the update cycle generally used in Medicare. We believe that this move will reduce the hospital industry's frustration with the many payment changes caused by Congressional delays and budget negotiations.

We have not had the opportunity to evaluate fully the recommendations of the Prospective Payment Assessment Commission (ProPAC). Our recommendation for the updates is contingent on the current situation and projections of relevant data. In addition, we note that the President's proposal to move the hospital update will, if enacted, change the market basket and, therefore, the updates for the hospitals. The President's budget assumed the market basket would increase by 4.5 percent for hospitals subject to the prospective payment system and by 4.6 percent for excluded hospitals. These estimates are consistent with our most current projections. A final recommendation on the appropriate percentage increases for FY 1993 will be made nearer the beginning of the new Federal fiscal year based on the most current

market basket projections available at that time. The final recommendation will incorporate our analysis of the latest estimates of all relevant factors, including ProPAC's recommendations.

Section 1886(d)(4)(C)(iv) of the Social Security Act, as enacted by section 6003(b)(2) of the Omnibus Budget Reconciliation Act of 1989, requires that the Secretary include in his report recommendations with respect to adjustments to the diagnosis-related group (DRG) weighting factors. At this time, we do not anticipate recommending any adjustment to the DRG weighting factors for FY 1993.

My staff and I look forward to discussing this recommendation with you.

Sincerely,

Louis W. Sullivan, M.D.

March 30, 1992.

The Honorable Thomas S. Foley,
Speaker of the House of Representatives,
Washington, D.C. 20515.

Dear Mr. Speaker: Section 1886(e)(3)(B) of the Social Security Act requires that the Secretary of Health and Human Services, not later than March 1, 1992, report to the Congress his initial estimate of the applicable percentage increase in payments for inpatient operating costs for FY 1993 that he will recommend for hospitals subject to the Medicare prospective payment system (PPS) and for excluded hospitals and units. This submission constitutes the required report.

President Bush's budget incorporates updates consistent with those mandated by current law. The budget recommends an update for hospitals subject to the PPS equal to the rate of increase in the hospital market basket minus 1.55 percentage points for urban hospitals and the rate of increase in the hospital market basket minus 0.55 percentage points for rural hospitals. For hospitals excluded from the PPS, the budget includes an average increase in the Tax Equity and Fiscal Responsibility Act limit equal to the rate of increase in the hospital market basket. In addition, the budget contains a legislative proposal to move the annual update for hospitals from October 1 to January 1 to conform with the update cycle generally used in Medicare. We believe that this move will reduce the hospital industry's frustration with the many payment changes caused by Congressional delays and budget negotiations.

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Commission (ProPAC). Our recommendation for the updates is contingent on the current situation and projections of relevant data. In addition, we note that the President's proposal to move the hospital update will, if enacted, change the market basket and, therefore, the updates for the hospitals. The President's budget assumed the market basket would increase by 4.5 percent for hospitals subject to the prospective payment system and by 4.6 percent for excluded hospitals. These estimates are consistent with our most current projections. A final recommendation on the appropriate percentage increases for FY 1993 will be made nearer the beginning of the new Federal fiscal year based on the most current market basket projections available at that time. The final recommendation will incorporate our analysis of the latest estimates of all relevant factors, including ProPAC's recommendations.

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My staff and I look forward to discussing this recommendation with you.

Sincerely,

Louis W. Sullivan, M.D.

Appendix D: Recommendation of Update Factors for Operating Cost Rates of Payment for Inpatient Hospital Services

I. Background

Several provisions of the Social Security Act (the Act) apply to setting update factors for services furnished in FY 1993 by hospitals subject to the prospective payment system and those excluded from the prospective payment system. Section 1886(b)(3)(B)(i) of the Act sets the FY 1993 applicable percentage increases in the operating cost standardized amounts for prospective payment hospitals equal to the hospital market basket percentage increase minus 1.55 percentage points for hospitals located in urban areas and

the market basket percentage increase minus 0.55 percentage points for hospitals located in rural areas. Section 1886(b)(3)(B)(ii) of the Act governs the target rate-of-increase limits for hospitals excluded from the prospective payment system and the hospital-specific rate applicable to sole community hospitals. In accordance with section 1886(d)(3)(A) of the Act, we are proposing to update the average standardized amounts, the hospital-specific rates and the target rate-of-increase limits for hospitals excluded from the prospective payment system as provided for in section 1886(b)(3)(B) of the Act, as set forth above. Based on the currently forecasted market basket increase of 4.3 percent for hospitals subject to the prospective payment system, the proposed updates in the standardized amounts are 2.75 percent for hospitals in urban areas and 3.75 percent for hospitals in rural areas. The proposed update in the hospital-specific rate applicable to sole community hospitals is 4.3 percent. The proposed update for hospitals excluded from the prospective payment system is based on the percentage increase in the market basket for these hospitals and equals 5.4 percent.

Sections 1886(e)(2)(A) and (3)(A) of the Act require that the Prospective Payment Assessment Commission (ProPAC) recommend to the Congress by March 1, 1992 an update factor that takes into account changes in the market basket index, hospital productivity, technological and scientific advances, the quality of health care provided in hospitals, and long-term cost effectiveness in the provision of inpatient hospital services.

In its March 1, 1992 report, ProPAC recommended update factors to the standardized amounts equal to the percentage increases in HCFA's market basket minus 1.45 percentage points for urban hospitals and the market basket rate of increase minus 0.45 percentage points for hospitals located in rural areas. Further, ProPAC recommended an update to the standardized amounts equal to 3.05 percent for hospitals located in urban areas and 4.05 percent for hospitals located in rural areas (based on a market basket estimate of 4.5 percent). The components of ProPAC's update factor recommendations are described in detail in the ProPAC report, which is published in appendix E to this document. ProPAC recommended the update for the hospital-specific rates applicable to sole community and Medicare-dependent, small rural hospitals be equal to the rural hospital

update; that is, the percentage increases in HCFA's market basket minus 0.45 percentage points, or 4.05 percent based on a market basket estimate of 4.5 percent. We discuss ProPAC's recommendations concerning the update factors and our responses to those recommendations below.

Section 1886(e)(4) of the Act requires that the Secretary, taking into consideration the recommendations of ProPAC, recommend update factors for FY 1993 that take into account the amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. Under section 1886(e)(5) of the Act, we are required to publish the recommended FY 1993 update factors that are provided for under section 1886(e)(4) of the Act. Accordingly, this appendix provided our recommendations of appropriate update factors, our analysis of the derivation of the amount of the update factors, and our responses to the ProPAC recommendations concerning the update factors.

II. Secretary's Recommendations

Under section 1886(e)(4) of the Act, we are recommending that the standardized amounts be increased by an amount equal to the market basket percentage increase minus 1.55 percentage points for hospitals located in urban areas and the market basket percentage increase minus 0.55 percentage points for hospitals in rural areas. We are recommending an increase of the market basket rate of increase minus 1.55 percentage points for the hospital-specific rate for sole community hospitals. With the exception of the higher update for the rural standardized amount, we believe that the hospital-specific rate should be updated by the same percentage increases as the standardized amounts. Our recommendation for a higher update to the rural standardized amount is intended to reduce the differential between the standardized amounts for other urban and rural hospitals, which is not an applicable consideration for hospital-specific rates.

We recommend that hospitals excluded from the prospective payment system receive, on average, an update equal to the percentage increase in the market basket that measures input price increases for services furnished by excluded hospitals. That market basket is currently forecast at 4.5 percent. However, we are also recommending that the amount of the update vary according to the base year used to establish the excluded hospital or unit's rate of increase. Those hospitals and

units whose base year for purposes of the rate of increase limit began during the period FY 1983 through FY 1987 would receive a higher update than hospitals whose base year was established in FY 1982 or after 1987. The amount of the recommended HCFA update is dependent on the actual base year, as follows:

Base year began in FY	FY 1993 general update	FY 1993 additional update	Recommended FY 1993 update
1982.....	2.9		2.9
1983.....	2.9	1.8	4.7
1984.....	2.9	3.8	6.7
1985.....	2.9	6.0	8.9
1986.....	2.9	3.9	6.8
1987.....	2.9	1.8	4.7
1988 and later.....	2.9		2.9

In recommending these increases, we have followed section 1886(e)(4) of the Act which indicates we should take into account the amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. In addition, as required by section 1886(e)(4) of the Act, we have taken into consideration the recommendations of ProPAC. Our responses to the ProPAC recommendations concerning the update factor are discussed below.

III. ProPAC Recommendation for Updating the Prospective Payment System Standardized Amounts

For FY 1993, ProPAC recommends that the standardized amount be updated by the following factors:

- The projected increase in the hospital market basket (which was estimated to be 4.5 percent in ProPAC's March 1, 1992 report) plus 0.2 percentage points to account for the different wage and salary price proxies used for the ProPAC market basket.
- A correction of -0.8 percent to reflect the forecast error in the FY 1991 market basket rate of increase.
- A discretionary adjustment factor of 0.0 percent composed of an allowance of 1.0 percent for scientific and technological advancement and an allowance of -1.0 percent for productivity improvement.
- An adjustment for case-mix change of -0.7 percent.
- A differential update of 0.85 percent for hospitals located in rural areas and -0.15 percent for hospitals located in urban areas, to reflect the phasing out of the differential in the standardized amounts between rural and other urban hospitals.

Overall, the net increase employing the above factors is the percentage increase in the hospital market basket minus 1.45 percentage points for urban hospitals and the market basket minus 0.45 percentage points for rural hospitals. Based on the market basket estimate of 4.5 percent used in its March 1, 1992 report, ProPAC recommends a differential update for urban and rural hospitals, with urban hospitals receiving a 3.05 percent update, and rural hospitals receiving a 4.05 percent update.

Response: We are recommending an update that is consistent with the Administration's budget proposal that all hospitals receive an update in their payments for FY 1993 based on the current market basket forecast with the adjustments set forth in section 1886(b)(3)(B)(i)(VIII), as added by section 4002(a)(1)(C) of Public Law 101-508. The latest forecast shows that the FY 1993 market basket has decreased from 4.5 percent, the figure used by ProPAC in determining its update recommendations, to 4.3 percent between the fourth quarter of 1991 and the first quarter of 1992.

Our recommendation is supported by the following analyses which measure changes in hospital productivity, scientific and technological advances, practice pattern changes, and changes in case mix:

- **Productivity:** At the beginning of the prospective payment system update process, HCFA established a conservative normative standard for hospital productivity increases of 1.0 percent per year, based on a review of the literature on historical and potential hospital productivity and average long-run productivity growth in the U.S. economy. In the short run, any increases in productivity in excess of 1.0 percent would be kept by hospitals as increases in operating margins. Productivity increases of more than 1.0 percent would be encouraged by this standard. We believe that substantial gains can be made in hospital productivity, and that we should continue to provide an incentive to increase productivity.

ProPAC also believes hospitals should be given an incentive for additional productivity improvement. ProPAC measures productivity as the ratio of hospital admissions (adjusted for case mix and outpatient services) per FTE employee (adjusted for changes in skill mix). ProPAC includes in its productivity measurement the effect of changes in practice patterns. We have traditionally treated historic practice pattern changes as a separate factor because they represent changes that have occurred in the nature of the

hospital product. This year, ProPAC assumes a productivity gain of at least 2.0 percent and recommends a -1.0 percentage point adjustment on the basis that any productivity gains should be shared equally by Medicare and hospitals.

- **Quality Enhancing New Science and Technology:** The new science and technology factor is intended to recognize technological changes that increase costs but also enhance health status. We have no empirical evidence that accurately sets the level for this factor. Typically, a specific new technology increases costs in some uses and decreases costs in other uses. Concurrently, in some situations, health status is improved while in other situations it may be unaffected or even worsened using the same technology. It is difficult to separate out the relative significance of each of the cost-increasing effects for individual technologies and new technologies. In the early years of the prospective payment system, ProPAC conducted several studies of new technology costs and concluded that they were fairly low. Those studies focused primarily on the acquisition costs of the new technologies but also looked at diffusion of use and operating costs. Project Hope, under contract with ProPAC, annually estimates the incremental operating costs of specific cost-increasing technologies. However, we know of no definitive studies that establish an appropriate level or range for this factor. ProPAC's adjustment is for the cost-increasing effect of new technologies only, and this year assumes the estimated costs for these technologies at +1.0 percent.

We believe that the ProPAC estimate may be overstated for several reasons. First, the estimate does not account for offsetting changes in revenue due to changes in DRG assignment. Second, it is not clear that all of the new technologies listed in ProPAC's study significantly enhance health status. To the extent the new technologies are not quality enhancing, an adjustment is inappropriate. Finally, some of the technologies have considerable potential for cost savings relative to the technologies they are replacing.

Until a usable measure for the incremental operating costs associated with the implementation of these new sciences and technologies is developed, we believe that this adjustment should be set at a conservative, stable level. We recommend an adjustment of +0.3 to +0.5 percent.

- **Improvements in Practice Pattern:** We measure practice pattern changes based on changes in average length of

stay since the beginning of the prospective payment system. Although we have no complete measure of changes in practice patterns, we believe this factor can be modeled appropriately based on this measure. The practice pattern adjustment is based on the belief that the costs on which the initial payment rates were based included a component of unnecessarily high costs reflecting ineffective practice patterns and that it is reasonable for HCFA to share in the savings in the long run.

Average length of stay declined dramatically during the first years of the prospective payment system and gradually increased in subsequent years. However, our latest data indicate that average length of stay declined again and has remained stable over the last few years. Based on updated data on changes in average length of stay and the cumulative practice pattern adjustment implicit in prior update recommendations, we estimate that a residual adjustment of up to -1.8 percent could be supported.

- **Impact of OSHA Rule:** In the December 6, 1991 Federal Register (56 FR 64004), the Occupational Safety and Health Administration (OSHA) published a final rule implementing regulations (29 CFR 1910.1030) requiring organizations to use a variety of means to reduce the risk of employees contracting blood-borne pathogens, including hepatitis B virus and human immunodeficiency virus. In that rule, OSHA estimates the impact on hospitals at 0.14 percent of revenues. We are therefore recommending an adjustment of +0.14 percent to account for these additional costs. ProPAC did not recommend any explicit adjustment for the effects of these regulations.

Overall, the combined adjustment for productivity, technology, practice pattern changes, and the new OSHA requirements could range from -2.36 to -0.36 percentage points.

- **Change in Case Mix:** Our analysis takes into account changes in case mix adjusted for changes attributable to improved coding practices and DRG reclassification and recalibration. We found that the observed increase in case mix was 2.5 percent during FY 1991. We estimate real case mix increased 1.0 to 1.25 percent. We define real case-mix change as actual changes in the mix (and resource requirements) of Medicare patients as opposed to changes in coding behavior that result in assignment of cases to higher-weighted DRGs but do not reflect greater resource requirements. This estimate is supported by past studies of case-mix change by RAND Corporation. In addition, we

estimate that DRG reclassification and recalibration in FY 1992 resulted in a 1.0 percent increase in the case-mix index when compared with the case-mix index that would have resulted if we had not made the reclassification and recalibration changes to the GROUPE. The resulting adjustment to account for changes in case mix during FY 1991, the most recent year for which data are available, is -2.5 to -2.25 percent (the sum of -2.5 percent, +1.0 to 1.25 percent, and -1.0 percent). The -2.5 and +1.8 percent figures used in the ProPAC framework represent, respectively, ProPAC's projection for observed case-mix change, and its projection for real case-mix change, including within-DRG case complexity change, during FY 1992. ProPAC's observed case-mix change is estimated, whereas our observed case-mix change is based on FY 1991 bills received through February 29, 1992. ProPAC does not make an adjustment for DRG reclassification and recalibration in its update recommendation (we note that Congress asks the Secretary for an estimate of these effects in our update recommendation).

• **Correction for Market Basket Forecast Error:** The FY 1991 estimated market basket percentage increase used to update the payment rates was 5.2 percent. Our most recent data indicate the actual FY 1991 increase was 4.4 percent, reflecting that the increase in wages was lower than projected. The resulting forecast error in the projected FY 1991 market basket rate of increase forecast was -0.8 percentage points. Our policy has been to make a forecast error correction if our estimate is off by 0.25 percent points or more. Therefore, we are recommending an adjustment of -0.8 percentage points to reflect this overestimation of the FY 1991 market basket. This matches ProPAC's recommended forecast error adjustment.

The following is a summary of the update ranges supported by our analyses compared to ProPAC's framework.

TABLE 1.—COMPARISON OF FY 1993 UPDATE RECOMMENDATION FRAMEWORKS

	HHS	ProPAC
Market Basket (MB)	MB	MB
Difference Between HCFA & ProPAC MB Forecasts ¹		+0.2
Subtotal	MB	MB +0.2

TABLE 1.—COMPARISON OF FY 1993 UPDATE RECOMMENDATION FRAMEWORKS—Continued

	HHS	ProPAC
Policy adjustment factors		
productivity	-1.0	-1.0
Science and technology	+0.3 to +0.5	+1.0
Practice patterns	-1.8 to 0	
OSHA requirements	+0.14	
Subtotal	-2.36 to -0.36	+0.0
Case mix adjustment factors:		
Observed case mix change	-2.5	-2.5
Real across DRG change	+1.0 to 1.25	+1.5
Real within DRG change effect of 1990:		
Reclassification and recalibration	+0.3	
Subtotal	-2.5 to -2.5	-0.7
Forecast error correction:	-0.8	-0.8
Total recommended update	MB -5.66 to MB -3.41	MB -1.3

¹ The difference between the HHS and ProPAC market baskets is due to a different treatment of the wage and employee benefit proxies used by ProPAC in its market basket.

While the above analysis would support a recommendation that there be no update in the standardized amounts applicable to urban hospitals and the hospital-specific rates applicable to sole community hospitals in FY 1993, we believe that it would be inappropriate, in view of commitments made as part of the 1990 budget agreement, to recommend an update other than market basket minus 1.55 percentage points for urban hospitals and the hospital-specific rates applicable to sole community hospitals.

In addition, we believe a differential update for the standardized amount applicable to rural hospitals is appropriate in order to phase out the differential between the rural and other urban standardized amounts, as

required by Pub. L. 101-508. Therefore, we are recommending that the rural standardized amount be updated by an additional 1.0 percentage point, for a total update of 3.75 percent (that is, market basket minus 0.55 percentage points). We note that we disagree with ProPAC's recommendation that the hospital-specific rates applicable to sole community hospitals be increased by the update factor applicable to the rural standardized amounts. We believe that the considerations used to develop the update recommendations for the urban standardized amounts are also applicable to the hospital-specific rates, and that the differential update applied to the rural standardized amounts to eliminate the difference between the rural and other urban standardized amounts is not a relevant consideration for the hospital-specific rates.

IV. ProPAC Recommendation for Updating the Rate-of-Increase Limits for Excluded Hospitals

ProPAC recommends an average update factor equal to the market basket rate of increase minus 0.4 percentage points for excluded hospitals and units. The 0.4 percentage point reduction represents a reduction of 0.7 percentage points to account for the forecast error in the FY 1991 market basket rate of increase for excluded units, a 0.2 percentage point increase to reflect the different compensation price proxies used by ProPAC, and an allowance for new technology of 0.1 percent. Further, ProPAC recommends an additional allowance based on the year the hospital or unit was excluded from the prospective payment system. Before FY 1989, excluded hospitals and units received the prospective payment system update, which was reduced to account for rapid growth in payments due to case mix increases. Since excluded facilities do not benefit from the payment-increasing effect of case-mix index change, ProPAC believes that these hospitals should have received the applicable full market basket increase for years prior to FY 1989. ProPAC recommends that the additional allowance to these hospitals be funded through the savings achieved from the 0.4 percentage point reduction included in its average update recommendation for excluded hospitals.

Response: We recommend an average update for excluded hospitals that

would result in total payments comparable to those that would result from an update equal to the market basket rate of increase. The market basket for excluded hospitals is currently estimated at 4.5 percent. However, we recommend that excluded hospitals and units whose base year began during the period FY 1983 through FY 1987 receive a higher update than hospitals whose base year began in FY 1982 or after FY 1987.

We recommend that excluded hospitals and units with an FY 1982 base year or a base year that began after FY 1987 receive an update equal to the market basket percentage increase minus 1.6 percent. The 1.6 percentage point adjustment is to account for the forecast error in the FY 1991 market basket rate of increase of 0.7 percentage points plus the forecast error in the FY 1990 market basket rate of increase of 0.9 percentage points. Generally, we believe that increased costs for quality-enhancing new technologies should be offset by productivity gains and that explicit adjustments in the rate-of-increase limit for productivity and new technology are inappropriate.

In addition, we agree with ProPAC that a higher update for hospitals and units that were excluded in the early years of the prospective payment system is appropriate. This is because the updates applied to excluded hospitals in FYs 1986, 1987, and 1988 were considerably less than the market basket rate of increase and were based on some considerations appropriate only to hospitals subject to the prospective payment system. We agree with ProPAC as to the basis for the cumulative positive allowance adjustment, which is consistent with our calculation of the compounded difference between the updates received and the market basket rate of increase, as described in the June 3, 1991 proposed rule (56 FR 25322).

Base year began in fiscal year	FYs subject to ceiling	Compound-ed adjustment
1982.....	1983-1988	-0.5
1983.....	1984-1988	2.1
1984.....	1985-1988	4.2
1985.....	1986-1988	6.9
1986.....	1987-1988	4.4
1987.....	1988	2.1

We also agree with ProPAC's recommendation that any additional update allowance be made in a budget neutral fashion. It is not clear that an additional expenditure is warranted, or that any increase in payments is more appropriately distributed to excluded hospitals through a differential update factor rather than through a more targeted approach. While some hospitals have been adversely affected by the rate-of-increase limits, others have managed to receive substantial incentive payments. Further analysis is needed to understand why some hospitals have fared well and others have not, before we can determine whether an across-the-board increase is more appropriate than one targeted toward groups of hospitals whose costs are systematically above the rate-of-increase limit. Additionally, the lower updates are only part of the explanation for why hospitals with early base years are more financially vulnerable than hospitals that more recently became subject to the rate-of-increase limits. Another consideration is that these hospitals have been subject to the limits for a longer period of time and, in the case of those hospitals with an FY 1982 or FY 1983 base year, have a target amount that was established before the prospective payment system was implemented. For these reasons, we are recommending a 2.9 percent update for hospitals with an FY 1982 base year, even though a lower update would appear warranted based on the cumulative difference between the

market basket increase and the update factors.

We believe any increase in aggregate payments to excluded hospitals and units, plus an additional update for hospitals and units is premature until these issues are more fully evaluated. In this regard, we note that the Secretary is required by section 4005(b) of Public Law 101-508 to report to Congress on recommendations for potential modifications to the rate-of-increase limits system as well as the possible replacement of that system with a prospective payment system. At the same time, we believe the analysis of the cumulative difference between the market basket rate-of-increases and the update factors supports a recommendation for differential updates. We have used the results of the analysis to determine differential update factors that will result in program outlays that approximate the outlays that would result from a 4.5 percent update. Our recommended update factor is 2.9 percent for all excluded hospitals and units, plus an additional update for hospitals and units that became subject to the ceiling during the period FY 1984 through FY 1988. The recommended updates are as follows:

Base year began in fiscal year	General update	HCFA recommended additional adjustment	HCFA recommended fiscal year 1992 update
1982.....	2.9		2.9
1983.....	2.9	1.8	4.7
1984.....	2.9	3.8	6.7
1985.....	2.9	6.0	8.9
1986.....	2.9	3.9	6.8
1987.....	2.9	1.8	4.7
1988 and later.....	2.9		2.9

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PROSPECTIVE PAYMENT
ASSESSMENT COMMISSION

REPORT AND
RECOMMENDATIONS
TO THE CONGRESS
MARCH 1, 1992



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March 1, 1992

The Honorable Dan Quayle
President of the Senate
United States Senate
Washington, DC 20510

Dear Mr. President:

I am hereby transmitting to the Congress the annual report of the Prospective Payment Assessment Commission as required by Section 1886(e)(3) of the Social Security Act as amended by Public Law 101-508. This report provides an overview of trends in Medicare spending and sites of care from 1980 to 1990. The report also contains 23 recommendations and addresses several additional concerns that reflect the Commission's collective judgment about issues of substantial importance to beneficiaries, hospitals, other providers, and the Medicare program.

Sincerely,

Stuart H. Altman, Ph.D.
Chairman

Enclosure

Prospective Payment Assessment Commission



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March 1, 1992

The Honorable Thomas Foley
Speaker
United States House of Representatives
Washington, DC 20515

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TABLE OF CONTENTS

Chapter	Page
EXECUTIVE SUMMARY	1
1. MEDICARE SPENDING AND SITES OF SERVICE	13
Facilities Involved in Medicare	16
Medicare Spending	16
Medicare Facility Utilization	19
Facility Capacity	20
Reasons for the Growth in Medicare Facility and Nonfacility Spending	21
Inpatient Hospital	21
PPS-Excluded Providers	22
Outpatient Facilities	23
Skilled Nursing Facilities	25
Hospital Swing Beds	26
Home Health Care	26
Hospice Care	28
Dialysis Facilities	28
Other Facilities, Providers, and Suppliers	29
Nonfacility Providers	29
Relationship of Utilization and Spending Trends to Patterns of Care	29
Goals of Medicare Payment Methods	31
Commission Payment Reform Activities	31
2. RECOMMENDATIONS	33
Recommendations for Fiscal Year 1993	36
Updating PPS Payments	36
Recommendation 1: Amount of the Update Factor for PPS Hospitals	36
Recommendation 2: Amount of the Update Factor for Hospitals Paid on the Basis of Hospital-Specific Rates	40
Recommendation 3: Updating Capital Payment Rates	40
Adjusting the Payment System	41
Recommendation 4: Level of Indirect Medical Education and Disproportionate Share Adjustments to PPS Operating Payments	41
Recommendation 5: Consistency of Indirect Medical Education and Disproportionate Share Adjustments to PPS Capital and Operating Payments	43
Recommendation 6: Improvements in Labor Market Definitions	44
Statement on Potential Major Refinements to the DRGs	46
Recommendation 7: Medicare Transfer Payment Policy	47
Recommendation 8: Payment for Hemophilia Blood Clotting Factor	48
Recommendation 9: Payment for Epilepsy Cases	49
Recommendation 10: Essential Access Community Hospital Program	50
Statement on PRO Review and Quality of Care	51
Updating and Adjusting Payments to PPS-Excluded Hospitals and Distinct-Part Units	52
Recommendation 11: Fiscal Year 1993 Update Factor for PPS-Excluded Hospitals and Distinct-Part Units	52
Updating Payments to Dialysis Facilities	54
Recommendation 12: Update Factor for Payments to Dialysis Facilities	55
Improving Hospital Outpatient Payment Policy	56
Recommendation 13: Outpatient Payment Reform	56
Recommendation 14: Medicare Volume Performance Standard	57

Recommendation 15: Cost Data Collection for Outpatient Providers	58
Recommendation 16: Beneficiary Liability	59
Recommendation 17: Quality of Care in Outpatient Settings	59
Recommendation 18: Payment for Hospital-Provided Outpatient ASC-Approved Surgery	60
Recommendation 19: Revision of the Classification System Used to Group Ambulatory Surgery Cases	61
Recommendation 20: Payment for Hospital-Provided Outpatient Radiology Services	61
Recommendation 21: Payment Adjustments for Hospital-Provided, ASC-Approved Surgery and Radiology Services	62
Improving Skilled Nursing Facility Payment Policy	63
Recommendation 22: Nursing Facility Wage Index	63
Recommendation 23: Nursing Facility Case-Mix Adjustment	64

APPENDIXES	65
A. Background Material and Analyses	67
Fiscal Year 1993 PPS Update	69
Fiscal Year 1993 Update for PPS-Excluded Hospitals and Distinct-Part Units	81
B. Technical Report Series	87
C. Biographical Sketches of Commissioners	99
D. Statutory Mandate of the Commission	105
E. Change in DRG Relative Weights from Fiscal Year 1991 to Fiscal Year 1992	115

Executive Summary

Executive Summary

In this report for fiscal year 1993, the Prospective Payment Assessment Commission (ProPAC) discusses trends in Medicare spending for facility services and their implications. The Commission also presents 23 recommendations and addresses several additional concerns regarding Medicare facility payment methods. This report reflects ProPAC's analysis and the collective judgment of its Commissioners about issues of substantial importance to enrollees, hospitals, other providers, and the Medicare program. The report is made directly to Congress, although the Secretary of Health and Human Services (HHS) is required to respond to the Commission's recommendations.

ProPAC's original mandate was to advise the Congress and the Secretary on the Medicare prospective payment system (PPS) for hospitals. The Commission continues to devote substantial effort to updating and improving policies for paying hospitals under PPS as well as those that are excluded. However, ProPAC's responsibilities have expanded over time to include analyzing and developing prospective payment policies for all facility services furnished to Medicare beneficiaries. The Congress also has asked ProPAC to examine and report on broader issues regarding the effectiveness and quality of health care delivery in the United States. The expansion of ProPAC's responsibilities provides an opportunity for the Commission to examine the interrelationships among alternative facility payment policies and to improve policies so that an appropriate continuum of care at a reasonable level of spending is encouraged.

MEDICARE SPENDING AND SITES OF SERVICE

When Medicare began, most covered services were provided in acute care hospitals and physicians' offices. But as the Medicare program added new benefits, and as medical practice patterns changed and new technological capabilities were developed, the number and types of services provided in outpatient and other settings have increased. Inpatient hospital services continue to account for the largest share of health

care spending, although that share is diminishing. An increase in the delivery of services in other sites has been encouraged by Medicare policies and payment incentives. As a result, new providers, facilities, and sites of care have grown rapidly, as has Medicare spending for services furnished outside the hospital.

Medicare payment policies are specific to the type of facility in which a service is provided. As sites of care have emerged, Medicare has developed payment policies for some new categories of providers. The Commission is responsible for analyzing current and proposed prospective payment policies for inpatient hospitals paid under PPS, PPS-excluded hospitals and distinct-part units, hospital outpatient services, skilled nursing facilities (SNFs), home health agencies, and renal dialysis facilities.

Among the other sites of care that Medicare does not specifically recognize for facility payment are ambulatory care centers, diagnostic imaging centers, lithotripsy centers, and outpatient psychiatric clinics. For payment purposes, these sites are often treated as physicians' offices or as physician-directed clinics. Thus, the covered services provided in these facilities are paid for according to Part B rules for physician and other ambulatory services.

Many services can be furnished in alternative settings, so payment policy for one type of facility may affect utilization and spending in others. A comparison of the rate of increase in spending across facility types suggests that the current fragmentation and inconsistency of Medicare payment policies across facilities and settings may be contributing to accelerating program expenditures. Between 1980 and 1990, spending per enrollee for hospital services rose 28 percentage points more than general inflation. Real spending per enrollee at other facilities recognized by Medicare increased 170 percent. Real Medicare expenditures per enrollee for physician services climbed 84 percent. This includes payments for many services provided in facilities not paid separately by

Medicare. A 20 percent growth in Medicare enrollees during the 1980s contributed to an 89 percent real increase in total program expenditures.

Medicare spending for inpatient hospital services is still the program's largest single expenditure category, totaling almost \$59 billion in 1990. Because the growth in spending for inpatient hospital services was slower than that for other types of facility and physician services, the proportion of Medicare spending on inpatient services fell from 67 percent in 1980 to 54 percent in 1990. At the same time, the share of Medicare spending on other recognized facilities increased from 10 percent to 19 percent.

The relatively slow increase in Medicare inpatient spending was due in part to the implementation of PPS. Before PPS, hospitals were reimbursed for the costs they incurred. Since the third year of PPS, payments per discharge have increased substantially less than operating costs per discharge.

Utilization changes have a major influence on Medicare spending patterns. The proportion of Medicare enrollees receiving services increased from 63 percent to 78 percent between 1980 and 1989. The proportion of Medicare enrollees using inpatient hospital services fell from 23.7 percent to 19.2 percent in the same period. The fall-off in admissions occurred in PPS hospitals; admissions to PPS-excluded hospitals and distinct-part units rose rapidly. Utilization of post-acute services in SNFs, rehabilitation hospitals, and home health care agencies also increased. Thus, the relatively slow growth in Medicare spending for inpatient acute care services and the large increases in spending for outpatient and other facility services resulted in part from a shift in the site of care. Increases in the number of services provided per beneficiary also contributed to higher expenditures.

Changes in the use of health care services, including the shift to outpatient settings, contributed to a nearly 20 percent increase in the average complexity of Medicare cases treated in PPS hospitals. These changes also led to a substantial increase in hospital outpatient utilization, with 46 percent of Medicare enrollees receiving these services in 1989, compared with 28 percent in 1980. Utilization of SNF services grew as well, peaking during 1988 and 1989 due to clarification of

coverage rules and improved benefits under the Medicare Catastrophic Coverage Act of 1988 (MCCA). SNF utilization declined following the repeal of the Act in 1990, although it remained above pre-MCCA levels. The use of home health care agency services rose sharply during the early 1980s, but leveled off in the mid-1980s. Home health visits have been climbing since coverage criteria were clarified in 1989. The number of beneficiaries receiving dialysis for end-stage renal disease (ESRD) doubled during the 1980s, and annual admissions to hospices rose steadily after the introduction of the hospice benefit in 1984, reaching 100,000 in 1990.

Changes in facility capacity mirrored those in utilization patterns. The number of PPS-eligible hospitals and beds both declined every year from the introduction of PPS in 1983 to 1990. Because total inpatient days fell even more rapidly, however, excess inpatient capacity increased. By contrast, the number of PPS-excluded hospitals rose, with psychiatric and rehabilitation hospitals and distinct-part units showing the largest growth. The number of outpatient facilities participating in Medicare also jumped dramatically after PPS was introduced. Ambulatory surgical centers (ASCs) rose 670 percent, while the number of home health agencies grew by 22 percent.

Payment methods and payment rates can vary when the same service is provided at different sites, thus influencing utilization. Hospitals paid under PPS receive a prospectively determined payment, based on patient diagnosis. Payment to PPS-excluded hospitals, on the other hand, is based on the hospital's own historical costs, trended forward. Skilled nursing facilities and home health care agencies are paid reasonable costs, subject to certain limits. Ambulatory services generally are covered under Part B of Medicare. For services provided in Medicare-recognized facilities, payments are made separately to the facility and to physicians. Ambulatory surgical centers and dialysis facilities are paid a prospective rate. Independent clinical laboratories are paid according to a fee schedule. Payment to most other Medicare-recognized outpatient facilities is based on either reasonable costs or reasonable charges.

The variation in payment methods and rates for the same service at different sites may introduce

inappropriate financial considerations into the clinical decisionmaking process. It may also contribute to the growth in service capacity and encourage inappropriate use of services. The Commission believes that Medicare payment policies should be designed to provide consistent financial incentives and appropriate payment amounts across the different types of providers and practitioners. Related to this, ProPAC believes that the payment systems should promote quality of care throughout an episode of illness. Thus, incentives created by Medicare payment policies should be consistent with the goals of ensuring both access to appropriate high-quality care throughout an episode of illness and cost-efficiency of the care delivered.

The interaction of payment policies for inpatient and outpatient services directly affects both where those services are provided and their quality. Because of this, incremental policy changes cannot be evaluated in isolation. Rather, efforts to alter and improve PPS need to be considered in the broad context of the entire system. The recommendations in this report are consistent with these beliefs.

SUMMARY OF THE RECOMMENDATIONS

In Chapter 2, ProPAC presents 23 recommendations for updating and improving Medicare payment policies. The Commission also comments on other issues of importance to the Medicare program that may require action in the near future. ProPAC believes these proposed changes are necessary for maintaining access to high-quality health care, encouraging hospital productivity and cost-effectiveness, and permitting the adoption of innovative and appropriate technological advances. The Commission developed its recommendations by setting priorities, analyzing information, and deliberating on the implications of alternative policies. ProPAC also pays close attention to the concerns of the Congress, the Administration, health care providers, third-party payers, enrollees, and the public. The recommendations are offered to comply with the Commission's statutory mandate and to contribute to an informed, open debate about hospital payment policy and the Medicare program. For fiscal year 1993, ProPAC focused on six broad areas:

- Updating PPS payments.
- Adjusting the payment system.
- Updating and adjusting payments to PPS-excluded hospitals and distinct-part units.
- Updating payments to dialysis facilities.
- Improving hospital outpatient payment policy, and
- Improving skilled nursing facility payment policy.

Updating PPS Payments—The Commission recommends fiscal year 1993 updates equal to the increase in the Health Care Financing Administration's (HCFA) PPS market basket minus 1.45 percentage points for hospitals in urban areas and market basket minus 0.45 percentage points for hospitals in rural areas. Based on current HCFA projections, these updates are 3.05 percent and 4.05 percent, respectively. The average update is market basket minus 1.3 percentage points, or 3.2 percent.

The update recommendation combines five components. First, the fiscal year 1993 HCFA market basket is forecasted to increase 4.5 percentage points. Second, 0.2 percentage points are added to better reflect the increases in hospital labor costs that are not adequately measured in HCFA's market basket. Third, an adjustment of -0.8 percentage points for errors in the fiscal year 1991 market basket forecast is made. Fourth, a net discretionary adjustment factor (DAF) of zero reflects the Commission's judgment that scientific and technological advancement should be funded out of productivity gains. Fifth, a -0.7 percentage point adjustment for case-mix change offsets the estimated extra revenues hospitals received in fiscal year 1992 from case-mix index (CMI) increases that were not due to treating sicker patients.

The Commission supports the phased elimination of the differential between the standardized amounts paid to hospitals in rural areas and to those in urban areas with fewer than one million people. Therefore, an additional 0.85 percentage points should be added to the update for rural hospitals, and 0.15 percentage points should be subtracted from the update for urban hospitals.

For hospitals paid on the basis of a hospital-specific rate, the Commission recommends an update equal to the rural update of 4.05 percent.

The update is only one source of the increase in total PPS payments to hospitals. Change in the case-mix index, which is estimated to rise 2.3 percent during fiscal year 1993, will also drive up payments. As a result, the average increase in per case payments, including CMI change and all of ProPAC's recommendations, is expected to be 5.6 percent in fiscal year 1993.

ProPAC believes there should ultimately be one payment for hospital inpatient operating and capital expenses. It therefore recommends the development of a single update factor for adjusting PPS operating and capital payments, consistent with the existing PPS operating update framework. This single update factor should be implemented for fiscal year 1994.

Adjusting the Payment System—The current indirect medical education (IME) adjustment more than adequately compensates hospitals for the increased costs associated with teaching activity. However, the financial performance of major teaching hospitals, especially those that serve a large share of low-income patients, is worse than that of other hospital groups. The Commission is concerned that the continued operation of these hospitals and the fulfillment of their unique role in the provision of health care might be impaired by a substantial immediate reduction of Federal support. The Commission therefore believes that gradual reduction of the IME adjustment to the appropriate level would be a prudent course of action. Thus, for fiscal year 1993, ProPAC recommends reducing the level of the IME adjustment from 7.7 percent to 7.0 percent for every 10 percent increase in teaching intensity, with the savings from this reduction returned to disproportionate share (DSH) teaching hospitals through an increase in the DSH adjustment for these hospitals.

Development of a single payment for operating and capital expenses would require a unified set of payment adjustments. ProPAC therefore recommends that, effective in fiscal year 1994, the indirect medical education and disproportionate share adjustments for capital payments should be made consistent with the IME and DSH adjustments for

PPS operating payments. A single IME adjustment factor should be based on an evaluation of the relationship between teaching intensity and combined Medicare operating and capital costs per case. To develop a consistent IME adjustment, the measure of teaching intensity used for operating payments—the ratio of residents per bed—should also be used for capital payments. In addition, to develop a consistent DSH adjustment, the criteria used to designate disproportionate share providers for the DSH operating adjustment should be applied to capital.

ProPAC has long believed that the current definition of labor market areas used to make wage index adjustments to PPS payment does not accurately reflect actual labor market conditions. The need to improve these definitions, which are used to construct the area wage index under PPS, was underscored by the recent geographic reclassification of more than 800 hospitals into different labor market areas. The Commission is working with HCFA and the American Hospital Association to develop by fiscal year 1994 an alternative approach to alleviate many of the problems inherent in the current definitions. ProPAC recommends that Congress await the outcome of this effort before taking further action on labor market definitions.

The Commission has been evaluating the impact of two alternative proposals for a major refinement of the diagnosis-related groups (DRG) patient classification system. Both proposals appear to permit more accurate classification of patients under PPS. Thus, payments to hospitals could more accurately reflect cost differences due to variations in severity of illness and other factors. However, further study would be needed to reach a final judgment regarding whether any of the proposed modifications is desirable. The Commission welcomes the views of hospitals and other entities as it continues to evaluate these proposals.

Medicare cases transferred out of one hospital and into another are paid a uniform per diem based on a DRG, up to the full DRG amount. In the Commission's view, these cases should be paid on a graduated per diem, up to the full DRG payment, in recognition of the higher costs associated with stabilization, evaluation, and surgery that generally take place early in a patient's hospital stay. ProPAC also recommends further examination of whether

hospitals have the appropriate incentives to receive and transfer patients, particularly with respect to outlier payments and for recuperative care.

The Commission has determined that current PPS payment policies provide adequate compensation to hospitals that treat Medicare beneficiaries with hemophilia. Therefore, it does not recommend reinstatement of an add-on payment for the costs of blood clotting factor provided to hemophilia patients.

ProPAC recommends that the Secretary evaluate and refine the current DRG assignment for patients with intractable epilepsy, particularly those receiving neurodiagnostic monitoring.

Medicare's Essential Access Community Hospital (EACH) Program is intended to encourage the development of rural regionalization plans with two levels of care. Rural primary care hospitals (RPHs) will provide emergency and temporary inpatient care. Essential access community hospitals will act as full-service referral hospitals to the RPHs. The program offers an option to hospitals that have recently closed or are considering discontinuing routine inpatient care. The Commission supports this attempt to increase overall system efficiency without sacrificing access to care, but believes that the current program's focus is too narrow. Therefore, ProPAC urges the Secretary to waive some of the program requirements on an individual case basis to increase hospital participation and to gain additional experience with alternative policies.

The Peer Review Organization (PRO) program should continue to track, at the case and facility levels, the care furnished Medicare beneficiaries, while developing the ability to monitor care at the regional and national levels. ProPAC therefore supports the development of the nationally representative Uniform Clinical Data Set (UCDS). However, it is concerned that monitoring quality of care at the case and facility levels will be deemphasized. The PROs should be funded at an appropriate level to allow them to perform all of these functions.

Updating and Adjusting Payments to PPS-Excluded Hospitals and Distinct-Part Units—The Commission recommends fiscal year 1993 updates of market basket minus 0.4 percentage points for PPS-excluded hospitals and distinct-part units. In addition, hospitals excluded from PPS before 1989

should receive a positive allowance. Based on HCFA's current projections, the update should be 4.2 percent before adding the positive allowance.

The update factor recommendation combines five components. First, the fiscal year 1993 HCFA PPS-excluded market basket is forecasted to increase 4.6 percentage points. Second, 0.2 percentage points are added to better reflect the increases in hospital labor costs that are not adequately measured in HCFA's market basket. Third, an adjustment of -0.7 percentage points for errors in the fiscal year 1991 market basket forecast is made. Fourth, a 0.1 percentage point allowance is recommended for scientific and technological advancement. Fifth, a positive allowance ranging from 2.1 to 6.9 percentage points should be given to hospitals excluded from PPS before 1989. This allowance reflects the difference between the market basket and the actual updates given in earlier years.

Updating Payments to Dialysis Facilities—The Commission does not now have adequate data on which to base a recommendation concerning an appropriate update for ESRD composite rate payments. It therefore urges the Secretary to expedite the development of the data necessary to evaluate the cost of providing dialysis services.

Improving Hospital Outpatient Payment Policy—ProPAC believes that a prospective payment system for outpatient services should be implemented. This system should ultimately include all providers of outpatient services. Reform of outpatient payment policies should take into account the relationship between costs and services across inpatient and outpatient settings. This would imply that the eventual unit of payment should be for a bundle of related services. At this time, however, the unit of payment should be based on individual services.

The outpatient payment system should avoid introducing inappropriate financial considerations into the clinical decisionmaking process. However, it should reward providers for delivering cost-effective quality care in the appropriate setting. ProPAC thus offers the following outpatient payment policy principles. First, the payment method for the technical or facility component should be consistent across sites, but the payment rate should be adjusted to reflect cost differences that have societal benefit, such as standby capacity or emergency capabilities.

Second, if services are included in the Medicare Volume Performance Standard (VPS) when delivered in free-standing settings, they also should be included in the VPS when provided in hospital outpatient departments. Finally, Part B coinsurance for prospectively paid outpatient services should be 20 percent of the payment amount Medicare allows, regardless of delivery site.

To support development of prospective payment for outpatient services, a mechanism for periodic collection of procedure-specific cost data in free-standing settings should be implemented. The Commission supports the research being conducted by the Physician Payment Review Commission (PPRC), and intends to work with both the Secretary and PPRC in assessing available data sources.

ProPAC is concerned about lack of quality oversight in the ambulatory care setting. The Secretary should enhance and further develop methods to assess the quality of care provided to Medicare beneficiaries in all outpatient settings.

In light of the principles outlined above, ProPAC examined current payment policies for outpatient ambulatory surgery and radiology services. It recommends that payment for ambulatory surgeries performed in the hospital outpatient setting should be fully prospective and based on national rates. The national rates, in turn, should be based on a revised classification system that applies to both free-standing and hospital-based ambulatory surgery facilities. The level of the national rates should be computed in a budget neutral fashion, using both average hospital costs and payments to free-standing ambulatory surgery facilities. The national rates should be updated annually, using an appropriate update factor.

The Commission also recommends that payment for outpatient radiology services performed in the hospital outpatient setting should be fully prospective and based on national rates. The payment rates should be computed in a budget neutral fashion, using both average hospital costs and the technical component of the Medicare Fee Schedule for physicians. The rates should be adjusted to reflect differences in labor costs and updated annually.

Improving Skilled Nursing Facility Payment Policy—ProPAC believes it is inappropriate to use

the current hospital wage index in calculating SNF cost limits. It recommends that the Secretary collect data on employee compensation and paid hours of employment for workers in nursing homes that receive Medicare patients. Using these data, the Secretary should develop a nursing home wage index to create cost limits for SNF payment.

The current SNF payment methodology does not recognize differences in the costs of care provided to different types of patients. Medicare's per diem payment for patients who require intensive nursing and rehabilitative care is the same as that for patients who require fewer resources. Since Medicare beneficiaries often need more intensive nursing care than other patients, the payment system creates financial disincentives for SNFs to treat Medicare beneficiaries. The Commission therefore supports the Secretary's efforts to develop and implement a case-mix adjustment to Medicare SNF payments under the Multistate Nursing Home Case Mix and Quality Demonstration.

RECOMMENDATIONS FOR FISCAL YEAR 1993

Updating PPS Payments

Recommendation 1: Amount of the Update Factor for PPS Hospitals

For fiscal year 1993, the PPS standardized payment amounts should be updated to account for the following factors:

- The projected increase in the Health Care Financing Administration (HCFA) PPS market basket index, currently estimated at 4.5 percent;
- An upward adjustment of 0.2 percentage points, to reflect the difference between the ProPAC and HCFA market baskets;
- A correction for substantial error in the fiscal year 1991 market basket forecast of -0.8 percentage points;
- A net discretionary adjustment factor of zero; and
- A net adjustment of -0.7 percentage points for case-mix change.

In addition, a positive adjustment of 0.85 percentage points for hospitals in rural areas and a negative adjustment of 0.15 percentage points for hospitals in large urban and other urban areas should be made to reflect a continuation of the phase out of the differential in the standardized amounts between rural and other urban hospitals.

Recommendation 2: Amount of the Update Factor for Hospitals Paid on the Basis of Hospital-Specific Rates

The Commission believes that payments based on hospital-specific base-year costs for sole community hospitals and for small rural Medicare-dependent hospitals should be updated by the same factor that applies to the PPS rate for rural hospitals.

Recommendation 3: Updating Capital Payment Rates

The Commission recommends that a single update factor be developed for adjusting PPS operating and capital payment rates. The update framework should be consistent with that currently used by ProPAC to develop the PPS operating rate update recommendation, and should be put into use for fiscal year 1994.

Adjusting the Payment System

Recommendation 4: Level of Indirect Medical Education and Disproportionate Share Adjustments to PPS Operating Payments

The Commission recommends that the indirect medical education adjustment to PPS operating payments be reduced from its current level of 7.7 percent to 7.0 percent for fiscal year 1993. This reduction should be implemented in a budget neutral fashion, with the anticipated decrease in indirect medical education payments returned to teaching hospitals that are designated as disproportionate share providers through a corresponding increase in their disproportionate share adjustment percentages.

Recommendation 5: Consistency of Indirect Medical Education and Disproportionate Share Adjustments to PPS Capital and Operating Payments

The Commission recommends that the same level of indirect medical education and disproportionate

share payment adjustments be applied to both operating payments and the prospective component of capital payments, beginning in fiscal year 1994. Further, ProPAC believes that the methods of determining these adjustments to PPS operating payments should also be applied to capital payments. Therefore:

- The measure of teaching intensity used for the indirect medical education adjustments should be defined in terms of the ratio of residents per bed, and
- The criteria for designation as a disproportionate share provider should be based on urban or rural location and number of beds.

These changes would better reflect the policy objectives of the Congress in defining and setting the levels of the payment adjustments. They would also be consistent with the principle of incorporating capital into the PPS rate.

Recommendation 6: Improvements in Labor Market Definitions

The Commission believes that the current PPS labor market definitions need to be improved or replaced as soon as possible. Suitable alternative definitions, however, are not immediately available. In cooperation with the American Hospital Association and the Health Care Financing Administration, ProPAC is developing alternative labor market definitions that may alleviate many of the current problems. On the basis of this effort, the Commission hopes to be able to recommend substantially revised labor market definitions for fiscal year 1994.

Potential Major Refinements to the DRGs

The Commission has recently completed a partial evaluation of the impact of alternative proposals for major refinement of the DRGs. The results indicate that these refinements would allow more accurate classification and payment for Medicare cases. Further study would be needed, however, to reach a final judgment regarding the desirability of any of the proposed modifications. Therefore, ProPAC is not recommending adoption of major changes at this time. The Commission is interested in the views of hospitals and other entities as it continues to assess the desirability and impact of these refinements.

Recommendation 7: Medicare Transfer Payment Policy

Cases transferred out of a hospital should be paid based on a graduated per diem up to the full DRG payment to recognize the higher daily costs associated with the first few days in a patient stay. In addition, outlier payment policy should be reexamined, particularly with respect to transfer cases received by a hospital. The Commission believes that hospitals are penalized by the current payment for transfers and that further examination of whether hospitals have the appropriate incentive to transfer patients, particularly with respect to recuperative care, is warranted.

Recommendation 8: Payment for Hemophilia Blood Clotting Factor

The Commission believes that current PPS payment policies are adequate to prevent significant payment inequities for hospitals that treat Medicare beneficiaries with hemophilia. Therefore, ProPAC does not recommend reinstatement of an add-on payment for the costs of blood clotting factor provided to hemophilia patients. However, should the current situation change, the Commission may reevaluate this issue.

Recommendation 9: Payment for Epilepsy Cases

The current DRG assignment should be revised to account for the resource requirements of patients with epilepsy receiving intensive neurodiagnostic monitoring.

Recommendation 10: Essential Access Community Hospital Program

The Commission recommends that the Secretary waive, on an individual case basis, some of the requirements for participation in the Essential Access Community Hospital Program. This would encourage increased hospital participation and allow the Secretary to gain additional experience with alternative policies. Over time, policies should be expanded to target the larger group of hospitals that should continue to operate but offer limited, less specialized inpatient services. By refocusing these hospitals' operations, the Commission believes that overall system efficiency may be improved without sacrificing access to care.

PRO Review and Quality of Care

The Commission believes the Peer Review Organization program should continue to monitor, at the case and facility levels, the care furnished to Medicare beneficiaries. Although the Commission commends the planned expansion of epidemiologic patterns of care studies using the Uniform Clinical Data Set, these more general analyses should not replace all case-level and facility-level quality review. Further, funding should be sufficient to allow PROs to perform case-level and facility-level review, as well as more general analyses of broad patterns of care.

Updating and Adjusting Payments to PPS-Excluded Hospitals and Distinct-Part Units**Recommendation 11: Fiscal Year 1993 Update Factor for PPS-Excluded Hospitals and Distinct-Part Units**

For fiscal year 1993, the target rate of increase for PPS-excluded hospitals and distinct-part units should be updated to account for the following factors:

- The projected increase in the HCFA PPS-excluded hospital market basket, currently estimated at 4.6 percentage points;
- An upward adjustment of 0.2 percentage points, to reflect the difference between HCFA's market basket and that recommended by ProPAC;
- A correction for fiscal year 1991 market basket forecast error of -0.7 percentage points; and
- An allowance for scientific and technological advancement of 0.1 percentage points.

In addition, a positive allowance should be given to TEFRA providers that entered the program before fiscal year 1989, depending on the year on which their target rates were based. This allowance should reflect the difference between the actual updates given to their target rates in earlier years and the market basket for those years. It should result in aggregate payments that are budget neutral with respect to the legislated update.

Updating Payments to Dialysis Facilities

Recommendation 12: Update Factor for Payments to Dialysis Facilities

The Commission is not recommending an increase in payments for dialysis services at this time. Currently, data are inadequate to assess the relationship between the payments and the costs of furnishing various types of dialysis services in different settings. The Commission recommends that HCFA expedite work necessary to complete its database of unaudited dialysis facility cost reports. In addition, HCFA should annually audit the cost reports of a representative sample of dialysis facilities and maintain a database with this information.

Improving Hospital Outpatient Payment Policy

Recommendation 13: Outpatient Payment Reform

The Commission believes that a prospective payment system for outpatient services should be implemented. Outpatient facility payment reform should ultimately include all providers of outpatient services, such as hospitals, physicians' offices, and free-standing ambulatory surgical centers.

The same payment method should apply to the facility or technical component of all services. The payment rate, however, should be adjusted to reflect justifiable cost differences such as wages and case mix. Further, cost differences that have some societal benefit like, for example, standby capacity and emergency capabilities, should also be reflected in the payment rate. Where feasible, the unit of payment should be based on bundled related services.

Recommendation 14: Medicare Volume Performance Standard

Services provided in the hospital outpatient setting should be included in the Medicare Volume Performance Standard (VPS) to the extent that these services are included when provided in other settings. Certain services, such as laboratory tests and therapy, currently are included in the VPS

when they are furnished in free-standing settings. The Commission believes that hospital-provided services should also be incorporated in the VPS. Their inclusion will make incentives to control volume consistent across sites of care.

Recommendation 15: Cost Data Collection for Outpatient Providers

A mechanism for periodic collection of procedure-specific cost data in free-standing settings, including physicians' offices and ambulatory surgical centers, should be implemented.

Recommendation 16: Beneficiary Liability

Beneficiary Part B coinsurance for hospital outpatient services that are paid for prospectively should be limited to 20 percent of the payment amount allowed by Medicare.

Recommendation 17: Quality of Care in Outpatient Settings

The Commission is concerned about the lack of Federal quality oversight in many ambulatory care settings. As more services are furnished in outpatient settings, ProPAC believes the Secretary should enhance existing methods and develop new ones to assess and monitor the quality of care provided to beneficiaries in these settings.

Recommendation 18: Payment for Hospital-Provided Outpatient ASC-Approved Surgery

The Commission believes that payments for ambulatory surgery performed in the hospital outpatient setting should be fully prospective based on national rates adjusted for area wage differences. The payment rates should be established using average hospital costs and free-standing ASC payments. These rates should be computed in a budget neutral fashion; that is, aggregate spending should neither increase nor decrease. National rates should be based on the classification system used to determine payments to free-standing ASCs. However, the Commission believes this classification system should be revised. The rates should be updated annually using an appropriate update factor.

Chapter 1

Medicare Spending and Sites of Service

Recommendation 19: Revision of the Classification System Used to Group Ambulatory Surgery Cases

The Secretary should revise the classification system used to group ambulatory surgery cases for payment. Cases treated in both hospitals and free-standing ambulatory surgical centers should be used to establish the payment groups.

Recommendation 20: Payment for Hospital-Provided Outpatient Radiology Services

The Commission believes that payments for radiology services provided in the hospital outpatient setting should be fully prospective based on national rates adjusted for area wage differences. The payment rates should be established using average hospital costs and the technical component of the Medicare Fee Schedule for physicians. These rates should be computed in a budget neutral fashion; that is, aggregate spending should neither increase nor decrease. The national rates should be updated annually using an appropriate update factor.

Recommendation 21: Payment Adjustments for Hospital-Provided, ASC-Approved Surgery and Radiology Services

The Commission believes that national prospective payment rates for ASC-approved ambulatory surgery and radiology services should be adjusted to reflect differences in labor costs. This adjustment should take into account the appropriate labor share and occupational mix of ASC-approved surgery and radiology services in the hospital outpatient setting. The Secretary should conduct additional research to determine whether other adjustments are warranted.

Improving Skilled Nursing Facility Payment Policy**Recommendation 22: Nursing Facility Wage Index**

The Secretary should collect data on employee compensation and paid hours of employment for nursing facilities that care for Medicare SNF patients. Once these data become available, the Secretary should develop a nursing facility wage index and use it to adjust Medicare SNF payments.

Recommendation 23: Nursing Facility Case-Mix Adjustment

The Commission believes that the payment system should recognize differences in the costs of care for different types of patients. Therefore, it supports the Secretary's efforts to develop and implement a case-mix adjustment to Medicare SNF payments under the Multistate Nursing Home Case Mix and Quality Demonstration. If the case-mix adjustment developed under the demonstration proves to be appropriate, it should be implemented.

Chapter 1

Medicare Spending and Sites of Service

The Medicare program today covers acute and post-acute care services provided in many different settings. When Medicare was enacted in 1965, the primary settings were acute care hospitals and physicians' offices. This has been changing, however, as the Medicare program has expanded and added benefits such as home health, hospice, and dialysis services. Changes in practice patterns and the development of new technological capabilities have also fostered the treatment of patients outside the hospital. All these factors have led to significant changes in how and where Medicare beneficiaries are treated.

New providers, facilities, and sites of care have grown rapidly; in many instances, the same service can be provided in a variety of settings. Home health agencies, skilled nursing facilities (SNFs), and rehabilitation facilities often provide similar post-acute care services. In many cases, these services can be used to shorten and reduce the cost of a beneficiary's inpatient hospital stay.

Spending for services delivered outside the hospital has increased markedly. Medicare payment is specific to the type of facility in which the service is offered. The payment method for a cataract extraction, for example, differs depending on whether the procedure is performed in an inpatient or outpatient hospital setting, a free-standing ambulatory surgical center (ASC), or a physician's office.

The current Medicare benefit and payment system, therefore, is made up of fragmented and sometimes inconsistent payment policies across the various facilities and settings. These policies may not encourage the most efficient use of resources or the most appropriate care. The coverage of and payment for services furnished by many new providers and facilities may make services for

Medicare beneficiaries more accessible. On the other hand, the proliferation of facilities also contributes to the rapid growth in Medicare spending and may make it more difficult for beneficiaries to receive quality care at a reasonable price.

The Prospective Payment Assessment Commission's (ProPAC) original mandate was to advise the Congress and the Secretary of Health and Human Services (HHS) on the Medicare prospective payment system (PPS) for hospitals. This role has since expanded to include payment for hospital outpatient services, excluded hospitals and units, skilled nursing facilities, dialysis treatments for end-stage renal disease (ESRD) patients, and home health services. The broadening of ProPAC's responsibilities gives the Commission an opportunity to examine the interrelationship among alternative facility payment policies and to devise policies that encourage an appropriate continuum of care at a reasonable level of spending. Only through a careful analysis of the complex array of providers, benefits, and payment methods can such policies be developed.

This chapter gives an overview of the facilities that provide services to Medicare beneficiaries. It focuses on Medicare expenditures across the various facilities and explains the reasons for their growth. The first section reviews the types of facilities participating in the Medicare program. Medicare spending, utilization, and capacity. This discussion provides background on how the program has evolved over the past decade. The chapter then examines the reasons for Medicare spending growth by facility type, focusing on payment policy and utilization effects. This is followed by a description of the relationship between utilization and spending trends by taking a broader look at how those forces interact and affect total Medicare

Table 1-1. Provider and Facility-Specific Payment Policies

Provider/Facility	Method of Payment
Medicare-recognized Part A providers ^a	
Hospitals (inpatient)	PPS and costs subject to TEFRA limits
Skilled nursing facilities	Costs subject to limits
Home health agencies	Costs subject to limits
Hospice programs	Cost-related prospective payment
Medicare-recognized Part B providers ^b	
Hospitals (outpatient)	Varies by service
Comprehensive outpatient rehabilitation facilities	Reasonable costs
Rehabilitation agencies and clinics	Reasonable costs
Other Part B facilities recognized by Medicare	
Ambulatory surgical centers	Prospective rate
Dialysis facilities	Prospective rate
Cardiac rehabilitation facilities	Reasonable charge
Independent clinical laboratories	Fee schedule
Physical and occupational therapy practices	Reasonable charges subject to salary equivalency guidelines
Rural health clinics	Reasonable costs

^a For beneficiaries with Part B but no Part A coverage, some of the services furnished by these providers are covered as a Part B benefit.

^b Includes ambulance and portable X-ray suppliers.

SOURCE: Information compiled by ProPAC.

expenditures and patterns of care. The chapter ends by highlighting Commission activities related to developing and refining prospective payment for these various facility-based providers.

FACILITIES INVOLVED IN MEDICARE

Medicare beneficiaries receive services in a variety of facilities (see Table 1-1). This section focuses on the major types of facilities included in the Commission's mandate: inpatient hospitals paid under PPS, hospitals and units excluded from PPS, outpatient hospital care, skilled nursing facilities, home health agencies, and renal dialysis facilities. In addition, the section examines changes in spending for independent laboratory, hospice, and physician services. Although Medicare recognizes a number of other facilities and providers for payment, they are not discussed here since they account for relatively low expenditures, and data on them are limited.

There are many additional sites of care that Medicare does not recognize for facility payment, but where specific services furnished are covered under Part B rules (see Table 1-2). In these cases, the facility does not have to meet conditions of program participation. Many of these sites of care are

treated as physicians' offices or physician-directed clinics.

Medicare Spending

Medicare spending continues to rise at near double-digit rates, despite a decade of intensified attempts at cost control. Medicare Part B expenditures for physician and other ambulatory services have grown much faster than spending under Part A, which covers hospitals and some other facility services. Between 1980 and 1990, Part B spending increased by more than 280 percent, while spending under Part A rose by about 160 percent. By contrast, general inflation in the U.S. economy during that period was 57 percent.

Between 1980 and 1990, total Medicare spending per enrollee increased by 147 percent. The 28 percent growth in spending per enrollee, adjusted for inflation, was much less in inpatient hospitals than in other settings (see Figure 1-1). Real growth in spending per enrollee increased fastest in other facilities recognized by Medicare (SNF, home health agencies, hospices, outpatient facilities, and clinical laboratories), a cumulative 170 percent between 1980 and 1990. The real growth in physician spending per enrollee was about 84 percent.

Table 1-2. Sites of Care Without Specific Medicare Policies

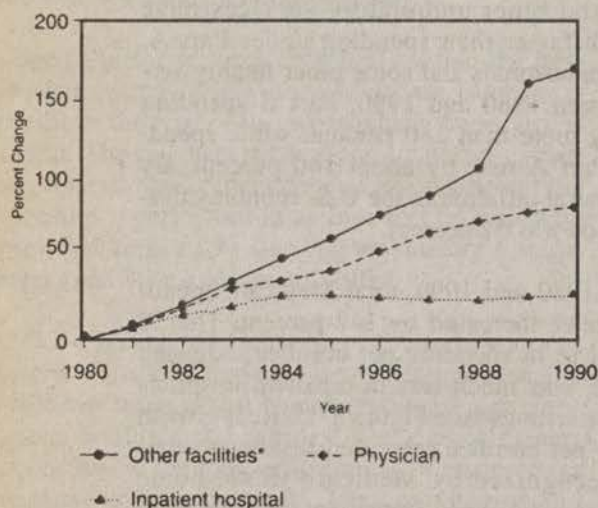
Type of Provider	Major Services Offered
Ambulatory care centers	Primary urgent care, occupational medicine, diagnostic imaging, rehabilitation/sports medicine, psychiatric treatment, substance abuse treatment
Diagnostic imaging centers	X-ray, mammography, ultrasound, magnetic resonance imaging, computerized axial tomography scans
Cancer centers: comprehensive radiation oncology	Radiation therapy, chemotherapy, cancer screening and prevention, patient education, rehabilitation
Women's centers	Mammography, breast services, premenstrual syndrome care, diabetes care/education, pap smear
Lithotripsy centers	Extracorporeal shock wave lithotripsy for kidney stone removal
Outpatient psychiatric clinics	Psychiatric treatment, medication monitoring, substance abuse treatment, suicide counseling
Pain clinics	X-ray, psychological testing, laboratory tests, physical examinations, drug therapy, physical therapy

SOURCE: Project HOPE under contract to ProPAC.

The change in the growth of Medicare spending has shifted the proportion of expenditures accounted for by hospitals and other services. In 1980, about 67 percent of Medicare spending was for

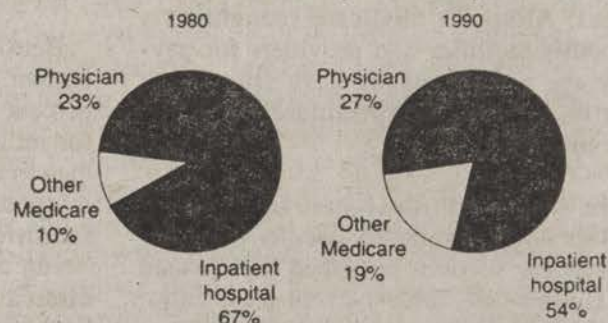
inpatient hospital services, 23 percent was for physician services, and 10 percent was for other program benefits (see Figure 1-2). By 1990, only 54 percent of Medicare spending was for inpatient hospital services, and 27 percent was for physician services. Other services accounted for 19 percent of total Medicare spending.

Spending for inpatient hospital services is still by far the largest single expenditure category in Medicare, totaling almost \$59 billion in 1990 (see Table 1-3). The growth in spending for inpatient

Figure 1-1. Cumulative Growth in Real Medicare Spending Per Enrollee, 1980-1990 (In Percent)

*Other facilities include outpatient hospitals and other included providers, skilled nursing facilities, home health agencies, hospices, and independent laboratories.

SOURCE: Health Care Financing Administration, Office of the Actuary.

Figure 1-2. Total Medicare Spending, by Type of Facility or Service, 1980 and 1990 (In Percent)

SOURCE: Health Care Financing Administration, Office of the Actuary.

Table 1-3. Estimated Medicare Benefit Payments, by Type of Service, 1980-1990

Year	Part A								Part B			
	Total Medicare		Inpatient		Skilled Nursing		Home Health Agency*		Physician		Outpatient	
	Payments (In Billions)	Percent Change	Payments (In Billions)	Percent Change	Payments (In Billions)	Percent Change	Payments (In Billions)	Percent Change	Payments (In Billions)	Percent Change	Payments (In Billions)	Percent Change
1980	\$ 36.5	--	\$24.4	--	\$0.4	--	\$0.8	--	\$ 8.5	--	\$2.0	--
1981	43.7	19.8%	29.2	19.7%	0.5	9.5%	1.1	29.1%	10.1	19.5%	2.4	19.2%
1982	51.2	17.3	33.8	15.7	0.5	9.3	1.4	30.9	12.2	20.2	2.8	19.1
1983	58.1	13.5	37.6	11.2	0.5	6.7	1.8	28.3	14.3	17.2	3.3	16.4
1984	64.8	11.5	41.9	11.4	0.6	6.9	2.1	19.0	15.6	9.7	3.8	14.2
1985	69.9	7.9	44.3	5.7	0.6	2.9	2.2	5.3	17.2	9.8	4.4	16.8
1986	75.4	7.8	45.8	3.5	0.6	0.2	2.2	1.0	19.6	14.0	5.3	20.1
1987	81.7	8.4	48.0	4.7	0.6	9.0	2.2	-0.5	22.2	13.3	6.2	17.7
1988	88.9	8.8	50.8	5.9	1.0	51.7	2.4	8.5	24.5	10.5	7.0	13.1
1989	100.0	12.5	55.0	8.3	3.4	258.1	3.0	24.2	27.1	10.5	7.6	8.3
1990	108.4	8.4	58.9	7.1	2.4	-29.3	4.4	46.8	29.4	8.5	8.5	11.3

Note: Payments reported here are incurred expenditures rather than outlays.

* Includes Part B home health agency expenditures.

SOURCE: Health Care Financing Administration, Office of the Actuary.

hospital services, however, has been much slower than that for other facilities. Although data on spending by type of inpatient facility (PPS short stay or excluded provider) are limited, growth in spending was probably faster in excluded hospitals because the number of Medicare discharges from these providers increased substantially between 1985 and 1988, while discharges declined for short stay facilities. Excluded hospitals accounted for about 8 percent of Medicare inpatient spending in 1990.¹

Spending for outpatient hospital care and other facilities rose by more than 325 percent between 1980 and 1990, from \$2.0 billion to \$8.5 billion. Much of this increase was due to a shift in site of service delivery. Cataract surgery, which in the early 1980s was performed almost exclusively in the inpatient setting, is illustrative. By 1990, cataract surgery was performed almost exclusively in outpatient settings.

Spending for SNF care climbed from \$0.4 billion in 1980 to \$2.4 billion in 1990, a 500 percent increase. The rise was most pronounced in 1988 and 1989. Home health agency spending also rose markedly between 1980 and 1990. In 1980, it totaled about \$0.8 billion, but by 1990 had increased by almost 450 percent, to \$4.4 billion. Home health agency spending was the fastest growing part of the Medicare program in 1990.

Spending for hospice services was just over \$350 million in 1990—a marked increase since the benefit was first introduced in 1984. The magnitude of this spending is quite small, however, compared with expenditures in other parts of Medicare.

In 1989, spending for dialysis services totaled \$1.2 billion, with increases averaging 8.7 percent annually between 1984 and 1989.² The yearly increase in spending for dialysis treatment has been much more constant than that for other facilities due largely to greater numbers of patients served.

Specific data on spending in other Medicare-approved facilities are available only for independent laboratories. Expenditures for these laboratories rose dramatically between 1980 and 1990, spiraling more than 1,000 percent from \$139 million to \$1.5 billion.

Medicare spending for physician services totaled almost \$30 billion in 1990, an increase from \$8.5 billion in 1980. Although the growth in this spending category slowed in the latter part of the decade, it was still substantially faster than that for inpatient hospital services and more than twice the increase in general inflation. Real spending per enrollee rose by 84 percent during the 1980s. Spending controls placed on physicians, such as physician fee freezes, may have had some effect on the slower growth seen by the end of the decade.

Table 1-4. Trends in Medicare Enrollment, 1980-1991 (In Millions)

Year ^a	Number of People		
	Total	Aged	Disabled
1980	28.5	25.5	3.0
1981	29.0	26.0	3.0
1982	29.5	26.5	3.0
1983	30.0	27.1	2.9
1984	30.5	27.6	2.9
1985	31.1	28.2	2.9
1986	31.7	28.8	3.0
1987	32.4	29.4	3.0
1988	33.0	29.9	3.1
1989	33.6	30.4	3.2
1990	34.2	30.9	3.3
1991 ^b	35.0	31.6	3.4

^a As of July of the specified year.^b Estimated.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy, and the Office of the Actuary.

Medicare Facility Utilization

Utilization trends for Medicare services in the different sites are related to two basic factors: changes in the number of Medicare enrollees, and changes in treatment patterns due to new technologies and physician practice styles. The interaction of these two factors helps explain a major portion of spending growth.

Between 1980 and 1990, Medicare enrollment increased by about 20 percent to 34.2 million (see Table 1-4). The rise in the number of enrollees, however, generally affects spending growth in all parts of the program equally, contributing about 2 percent annually.

Changes in the proportion of beneficiaries using services are more important in explaining some of the

variations in spending trends. Changing utilization is due to several factors. Among these are population aging, a greater supply of services and technological capabilities, and practice pattern changes. The percentage of enrollees receiving services under Medicare each year grew from 63 percent to 78 percent between 1980 and 1989 (see Table 1-5).

Spending growth for inpatient hospital services probably would have been much larger were it not for a decline in inpatient admissions and length of stay. The fall in inpatient use, however, was associated with a substantial increase in outpatient utilization. The decrease in length of stay coincided with greater utilization of SNFs, rehabilitation hospitals and units, and home health care agencies for post-acute care services.

Hospital admissions for those 65 and over decreased during the first three years of PPS. Since 1987, admissions have increased, but not as fast as the number of Medicare enrollees. The proportion of Medicare enrollees using hospital services fell from 23.7 percent in 1980 to 19.2 percent in 1989, an average annual decline of 2.3 percent. Overall, Medicare inpatient hospital utilization per enrollee has continued to drop, but much more slowly than between 1984 and 1986. Admissions to excluded hospitals and units, by contrast, increased substantially in the 1980s, rising by 43 percent between 1985 and 1988.

Medicare utilization of hospital outpatient services has increased notably. In 1980, 27.5 percent of Medicare enrollees used hospital outpatient facilities, compared with 45.8 percent in 1989. Higher outpatient utilization was due to the development of new technologies and changes in practice patterns, as has been noted. These caused a shift in services

Table 1-5. Aged and Disabled Persons Served by Medicare, 1980-1989 (Per 1,000 Enrollees)

Type of Coverage/Provider	Persons Served						Average Annual Percent Change 1980-1989
	1980	1982	1984	1986	1988	1989	
Total	633.2	638.2	681.3	726.9	761.7	778.9	2.3%
Hospital Insurance (Part A)	240.6	251.4	239.9	211.0	207.6	206.2	-1.7
Inpatient hospital	237.1	243.5	229.0	203.2	197.5	192.3	-2.3
Skilled nursing facility	9.2	8.7	10.0	9.7	11.9	19.3	8.6
Home health agency	25.9	39.7	49.9	50.3	48.8	51.0	7.8
Supplementary Medical Insurance (Part B)	650.5	653.5	697.5	748.9	789.6	810.3	2.5
Physician	629.9	696.1	674.8	725.9	768.7	792.6	2.6
Hospital-provided outpatient services	275.1	297.3	332.2	399.6	447.6	458.1	5.8

Note: Rates based on enrollment in Part A, Part B or both, as appropriate.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy.

from inpatient to outpatient settings, as well as an absolute growth in the number of services provided. The movement from inpatient to outpatient settings was further encouraged by Medicare policies and payment incentives.

Utilization also increased substantially for SNFs and home health agencies. In 1989, 1.9 percent of Medicare enrollees used skilled nursing facilities, compared with 0.9 percent in 1980. The number of covered days for SNF care increased markedly in 1988 and 1989, due largely to the clarification of coverage guidelines by the Health Care Financing Administration (HCFA) and to the Medicare Catastrophic Coverage Act of 1988 (MCCA). Utilization in 1990 declined from 1989 levels owing to repeal of the Act, but remained much higher than before the legislation was passed. The number of beneficiaries receiving SNF care continued to expand, however.

Use of home health agency services increased from 2.6 percent of enrollees in 1980 to 5.1 percent in 1989. There was a decided rise in home health visits through the early 1980s, although visits decreased in the 1985 through 1987 period. The early growth was due to the Omnibus Budget Reconciliation Act (OBRA) of 1980, which allowed more home health agencies to participate in the program. Recent growth in utilization is due partly to changes in coverage that expanded the number of beneficiaries covered and broadened the scope of home health agency care.

Medicare admissions to hospice programs have continued to increase since the hospice benefit was created in 1984. In fiscal year 1990, slightly more than 100,000 beneficiaries were admitted to these programs. The number of Medicare beneficiaries undergoing dialysis treatment doubled between 1980 and 1990 due to expanded medical indications.

The proportion of beneficiaries using physician services grew at a slower rate than for other facility services, 2.6 percent annually. However, almost 80 percent of enrollees used physician services in 1989, making this the most widespread benefit.

Facility Capacity

Increased total spending for certain types of facilities is partly explained by the greater number providing Medicare-covered services (see Table 1-6). This has a major effect on enrollees' access to and utilization of these services.

The number of short stay hospitals and beds has fallen every year since 1983. In 1990, there were 921,400 hospital beds, compared with slightly more than a million in 1983, a decline of 8.2 percent. Hospital admissions, however, decreased more rapidly; thus, excess capacity was substantially greater in 1990 than in 1983. While the number of short stay PPS-eligible hospitals has declined, the number of excluded hospitals has increased substantially. In 1990, there were 57 percent more excluded psychiatric hospitals and 173 percent more excluded rehabilitation hospitals than in 1984.

Table 1-6. Medicare Participating Facilities and Suppliers, 1980-1990

Facility/Supplier	1980	1982	1984	1986	1988	1990	Average Annual Percent Change
Hospitals	6,777	6,742	6,675	6,720	6,715	6,520	-0.4%
Short stay	6,104	6,070	6,038	5,994	5,856	5,549	-0.9
Long stay	673	672	637	726	859	971	3.7
Skilled nursing facilities	5,052	5,408	5,952	6,897	7,379	8,937	5.9
Home health agencies	2,924	3,415	4,684	5,978	5,769	5,730	7.0
Independent laboratories	3,447	3,581	3,801	4,138	4,487	4,879	3.5
Outpatient physical therapy providers	419	603	791	907	1,030	1,195	11.0
Portable X-ray suppliers	216	251	269	347	395	443	7.4
Rural health clinics	391	419	420	432	459	551	3.5
Comprehensive outpatient rehabilitation facilities	--	--	48	96	141	186	25.3
Ambulatory surgical centers	--	--	155	574	852	1,197	40.6
Hospices	--	--	108	268	449	825	40.3
Facilities providing services to ESRD beneficiaries	999	1,197	1,335	1,463	1,701	1,992	7.1

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy.

The supply of ambulatory services is growing rapidly. Although the specific number of facilities furnishing outpatient services is not readily available, data on increases in physicians and other information illustrate this trend. One important type of free-standing ambulatory provider for Medicare is the ambulatory surgical center. In 1990, there were 1,197 Medicare-participating ASCs—more than two and one-half times the number in 1985. Further, procedures performed at these centers rose almost 200 percent during this period, from fewer than 800,000 to more than 2.3 million.³

There have also been increases in nearly all types of other Medicare-eligible facility providers. The number of skilled nursing facilities furnishing services to Medicare beneficiaries climbed from 5,052 in 1980 to 8,937 in 1990, or 77 percent. The number of home health agencies grew by 96 percent during this period; by 1990, 5,730 home health agencies were participating in Medicare. The number of hospices also rose substantially between 1984 and 1990, largely because the benefit became a covered service in 1984.

The number of facilities providing renal dialysis expanded by about 100 percent between 1980 and 1990. The largest increase was among non-hospital renal dialysis facilities.

As noted earlier, numerous new ambulatory sites of care have emerged recently, among them ambulatory care centers, cancer centers, women's health clinics, and outpatient psychiatry clinics. Physicians, hospitals, for-profit entrepreneurs, and other entities have entered this market. The numbers of these other providers are unknown, however.

The supply of physicians also grew markedly over the decade. In 1980, there were about 468,000 physicians, compared with more than 600,000 in 1989, an increase of 28 percent. In contrast, the U.S. population grew by a little more than 9 percent.

REASONS FOR THE GROWTH IN MEDICARE FACILITY AND NONFACILITY SPENDING

Growth in Medicare spending across facilities has been influenced by a combination of factors: an

increase in the beneficiary population, changes in utilization and in sites of care, and inflation. Changing practice patterns and treatment protocols also have had an effect. The largest component of Medicare spending, inpatient hospital services, has seen the smallest growth, while spending in other types of facilities has accelerated more rapidly. Lower rates of growth for inpatient services and higher growth rates in other settings are also partially the result of different Medicare policies to control expenditures. This section describes spending trends observed in each of the major types of Medicare facilities.

Inpatient Hospital

Since fiscal year 1984, payments to short stay hospitals have been based on patient diagnosis. There are about 490 diagnosis-related groups (DRGs) for payment purposes. Payment rates are increased annually based on an update factor set by the Congress. The updates have been less than the per unit increase in costs for inpatient hospital services, which has helped constrain the growth rate in Medicare inpatient hospital spending. Under PPS, a hospital generally knows in advance what it will receive in payment for the services it provides, unless the case is exceptionally costly or the stay is much longer than normal. Before the advent of PPS, hospitals were paid on the basis of costs, subject to certain limits. This payment method provided minimal incentives for efficiency.

Prospective payment coincided with significant changes in how hospitals provide care. A number of trends, such as reductions in length of stay and admission declines, were occurring even before PPS was implemented. In addition to the evolution of practice patterns, the growing use of post-acute services such as SNFs, home health care, and rehabilitation hospitals may have occurred even without implementation of PPS.

Payment constraints have had a substantial influence on spending growth for inpatient hospital services. However, payments per discharge increased dramatically during the first year of PPS because of the way that initial PPS rates were set and increases in the case-mix index (CMI), which is used to measure the severity or amount of service provided to patients (see Table 1-7). Growth in spending has been much lower since then, due to payment rate

updates that were below the rise in costs. The extent to which these payment constraints have significantly affected increases in the total cost of providing services is unclear, however. In fact, hospital cost increases to furnish care have continued to outpace both general inflation and the hospital market basket, which measures the higher costs hospitals face to provide services.

Changes in the hospital CMI directly affected spending growth. Between fiscal years 1984 and 1990, the Medicare case-mix index rose by 19.2 percent due to the increasing complexity of patients or their treatments and coding practice changes. Greater patient or treatment complexity leads to higher resource costs. On the other hand, coding practice changes do not reflect higher costs, but do cause higher Medicare spending.

Falling inpatient hospital utilization and changing patterns of care—particularly the greater use of outpatient and post-acute care services—also have significantly affected Medicare spending. Lower utilization reduced aggregate spending increases for inpatient hospital services, but contributed to the notable increase in expenditures for other facilities. Changing the inpatient payment to a per case system provided incentives to increase utilization outside the hospital and decrease inpatient utilization. In turn, inpatient capacity, as measured by the

number of hospitals and beds, fell after 1983. However, excess capacity, as measured by empty beds, remains at historically high levels.

Total Medicare inpatient hospital payments rose by 40 percent between 1984 and 1990. Payment rate changes and case-mix increases contributed most to this growth. Utilization changes initially were responsible for decreasing spending growth and, later, for holding it close to the payment rate change. Admissions growth rates have been below historical levels since the implementation of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) and PPS. This trend indicates a continuing shift to treating patients in other settings.

PPS-Excluded Providers

When PPS was implemented, certain facilities were excluded: rehabilitation and psychiatric hospitals and distinct-part units, as well as children's, long-term, and cancer hospitals.⁴ PPS-excluded providers are paid on the basis of each facility's historical costs trended forward, with a limit placed on the rate of increase in per case reimbursable costs. These target rate-of-increase limits, established by TEFRA, are updated annually. The target rate per discharge is derived from hospital-specific Medicare costs in a base year, which varies depending on when the facility was constructed or converted to a PPS-excluded category. The

Table 1-7. Medicare Inpatient Hospital Utilization and Spending, 1980-1990

Year	Inpatient Admissions (In Thousands)	Spending Per Admission	Real Spending Per Admission*	Total Inpatient Spending (In Millions)
1980	10,628	\$2,281	\$2,281	\$24,242
1981	11,118	2,610	2,388	29,022
1982	11,309	2,969	2,558	33,580
1983	11,595	3,222	2,665	37,361
1984	11,358	3,666	2,914	41,638
1985	10,681	4,118	3,168	43,988
1986	10,232	4,442	3,330	45,452
1987	10,180	4,669	3,381	47,528
1988	10,229	4,919	3,418	50,316
1989	10,167	5,352	3,558	54,410
1990	10,282	5,669	3,608	58,288
Average annual percent change:				
1980-1985	0.1%	12.5%	6.8%	12.7%
1985-1990	-0.8	6.6	2.6	5.8

Note: Data excludes ESRD enrollees.

* 1980 dollars.

SOURCE: Health Care Financing Administration, Office of the Actuary.

payment mechanism provides hospitals with an incentive to keep cost increases close to the target increase level. There are no incentives to keep increases below the target rate or to control volume.⁵

PPS-excluded facilities have proliferated since 1984, but growth has not been uniform across all types of these providers (see Table 1-8). Those classified for payment as rehabilitation facilities grew most rapidly between 1984 and 1990. During this period, rehabilitation hospitals increased 173 percent, while rehabilitation distinct-part units rose 120 percent. Psychiatric facilities, which represent most PPS-excluded facilities, also have undergone rapid growth. Some existing psychiatric and rehabilitation hospitals were not recognized initially as excluded facilities and later applied for excluded status, which helps explain this trend.

Medicare discharges from most PPS-excluded facilities grew steadily from 1984 to 1988 (see Table 1-9). Most Medicare discharges from PPS-excluded facilities in 1988 were from psychiatric providers (63 percent of total PPS-excluded discharges). Rehabilitation providers treated about 33 percent of discharges from excluded facilities. The rest were treated at children's, long-term, and cancer hospitals. Distinct-part units, especially rehabilitation units, experienced the fastest growth in number of discharges during this period. The majority of beneficiaries receiving services in PPS-excluded facilities are treated in distinct-part units. By 1988, for example, nearly 70 percent of

Medicare discharges from rehabilitation providers were from distinct-part units; about 66 percent of Medicare discharges from psychiatric providers were from such units.

A portion of the growth in utilization and expenditures of excluded facilities can undoubtedly be attributed to PPS. Part of the decline in inpatient care in short stay general acute care hospitals, for instance, may be due to increases in the number of patients admitted to specialty facilities. Further, hospitals created distinct-part units to absorb overhead, excess capacity, and other resources, allowing them to lower inpatient costs. They could also reduce costs by discharging patients to the excluded unit to reduce length of stay. Additional providers saw opportunities for growth as PPS and other forces reduced inpatient stays. It is impossible to attribute how much of the expenditure growth in excluded facilities is due to PPS and how much to changing practice patterns or growing need. This is an example, however, of how cost control attempts in one sector of the health care system increased spending in another.

Outpatient Facilities

Ambulatory services generally are covered under Part B of Medicare. These services include medical visits, diagnostic laboratory tests, X-rays, and durable medical equipment. The services may be provided by hospitals, physicians, non-physician practitioners, and suppliers. Various methods are used by Medicare to pay for beneficiary care in outpatient settings; among them, reasonable costs or charges, prospective

Table 1-8. PPS-Excluded Hospitals and Distinct-Part Units, 1984-1990

Type of Facility	Year*							Percent Increase 1984-1990
	1984	1985	1986	1987	1988	1989	1990	
Hospitals								
Psychiatric	439	481	515	578	608	650	691	57%
Rehabilitation	49	68	79	84	100	120	134	173
Long-term	84	86	92	87	87	88	90	7
Children's	47	53	55	60	58	59	65	38
Cancer	--	--	--	8	8	8	8	--
Total	619	688	741	817	861	925	988	60
Distinct-part units								
Psychiatric	722	762	906	950	1,051	1,104	1,129	56
Rehabilitation	308	386	473	535	565	628	678	120
Total	1,030	1,148	1,379	1,485	1,616	1,732	1,807	75

* Numbers were determined as of September of each year except 1990, which was as of December 17, 1990.

SOURCE: Health Care Financing Administration, Health Standards and Quality Bureau.

rates, and blended rates. The payment method differs depending on the site and type of service.⁶

Medicare spending for outpatient services has grown substantially, climbing by 325 percent between 1980 and 1990. Spending growth in the outpatient setting has been much faster than that for either physicians or hospitals. From 1989 to 1990, for instance, hospital outpatient expenditures increased 11.3 percent. This compares with an increase of 8.5 percent for physician services and 7.1 percent for hospital inpatient services.

Due to technological advances and practice pattern changes, hospitals can offer more types of ambulatory services to their patients. For example, 81 percent of hospitals reported having an organized outpatient department in 1989, compared with 32 percent in 1979. About two-thirds of this growth occurred after the introduction of PPS. By 1989, nearly 95 percent of hospitals had ambulatory surgery services.⁷ Other outpatient services provided by hospitals include substance abuse treatment, psychiatric care, and rehabilitation.

One example of the changing medical services provided in hospital outpatient departments is surgery. The total volume of surgery in hospitals increased 16.8 percent from 1979 to 1989. Inpatient surgery actually declined 30 percent, while outpatient hospital surgery increased 304 percent. In 1979, outpatient surgical procedures accounted for only 14 percent of total surgeries. By 1989, they accounted for almost 49 percent.⁸

Medicare data on hospital outpatient utilization and spending per visit are rather limited. Information on total hospital outpatient spending, however, may help explain the causes of growth in outpatient expenditures (see Figure 1-3). In the 1980 to 1985 period, real spending growth in hospital outpatient services was due almost exclusively to increased spending per visit or to intensity. The causes for this trend cannot be broken down in detail, but probably include increasing complexity of cases, changing service mix, and higher charges. Some of the growth may also be explained by changes in the way visits are reported through unbundling. (Unbundling is the separate billing of services that were previously included in the same bill.) In the 1985 to 1990 period, the growth in visits due to technological advances and practice pattern changes was responsible for an increasing proportion of the total real growth in outpatient spending.

Some of the growth in Medicare outpatient spending can be attributed to PPS and the incentives to unbundle services by providing preadmission testing in hospital outpatient departments. Peer Review Organization precertification requirements for services like cataract surgery further contributed to the shift from inpatient to outpatient settings. Recent regulations expanding the preadmission time period from one to three days may reduce the number of outpatient visits that are separately reimbursable. Thus, while Medicare payment policy constrained per unit growth in outpatient spending by controlling payment rate increases, it provided

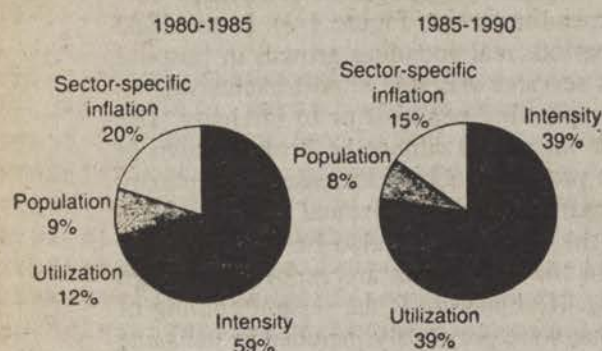
Table 1-9. Medicare Discharges from PPS-Excluded Hospitals and Distinct-Part Units, 1985-1988

Type of Facility	1985	1986	1987	1988	Percent Change 1985-1988
Psychiatric					
Hospitals	71,456	75,059	69,837	76,612	7.2%
Units	93,120	120,739	131,217	148,501	59.5
Total	164,576	195,798	201,054	225,113	36.8
Rehabilitation					
Hospitals	25,429	27,401	31,413	35,567	39.9
Units	45,650	57,566	68,813	82,723	81.2
Total	71,079	84,967	100,226	118,290	66.4
Long-term	14,477	14,666	13,712	14,304	-1.2
Children's	1,690	2,141	2,298	2,281	35.0

Note: These figures understate the actual number of Medicare discharges due to incomplete cost reports.

SOURCE: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

Figure 1-3. Factors Accounting for Real Growth in Hospital Outpatient Expenditures, 1980-1990 (In Percent)



SOURCE: Health Care Financing Administration, Office of the Actuary, Office of National Health Statistics.

no incentive to control volume or intensity—the primary contributors to higher spending.

Skilled Nursing Facilities

Medicare's skilled nursing facility benefit is limited to payment for extended care services furnished in SNFs. The Medicare SNF benefit covers skilled nursing services; physical, speech, and occupational therapy; medical social services; drugs and biologicals; whole blood and packed red blood cells; supplies, appliances, and equipment; and other diagnostic and therapeutic items or services provided by the SNF or a hospital with which the SNF has a transfer agreement.⁹

To be eligible for the SNF benefit under Part A, beneficiaries must need skilled nursing or other skilled rehabilitation services on a daily basis. In addition, they must have completed a minimum three-day hospital stay and must have been transferred to a SNF within 30 days after discharge from the hospital. The need for SNF care must have been caused by the medical condition that led to the hospital stay or by one that arose during the hospitalization. The benefit is limited to no more than 100 days of post-hospital care per spell of illness. A daily coinsurance payment, equal to \$81.50 in 1992, is required after the twentieth day of service.¹⁰

In general, Medicare reimburses SNFs under Part A on the basis of reasonable costs subject to certain limits. The limits apply nationwide but are

set separately for urban and rural facilities, and hospital-based and free-standing providers. The Medicare SNF payment method creates an incentive for providers to increase costs up to the limit. Because Medicare accounts for a relatively small share of SNF care, however, cost growth is influenced more by the payment policies of the Medicaid program, which is the dominant payer.

Between 1980 and 1990, expenditures for the Medicare SNF benefit climbed sixfold, from \$0.4 billion to \$2.4 billion (see Table 1-10). Most of this increase occurred after 1988. Between 1988 and 1989, expenditures for this benefit jumped an unprecedented 258 percent. This was caused by two major changes to the SNF program in 1988 and 1989 that dramatically affected utilization, namely clarification of coverage guidelines in 1988 and the Medicare Catastrophic Coverage Act.¹¹ Both of these increased the number of enrollees using the benefit. In 1990, SNF expenditures decreased 29 percent after the Act was repealed.

Between 1980 and 1990, Medicare SNF payments per covered day of service increased 96 percent, from an average of \$47.54 to \$93.12. This growth was 39 percentage points more than general inflation over the period.

Medicare SNF payments per person served remained fairly constant between 1980 and 1985, rising roughly 3 percent annually. However, in 1987 they began to accelerate, increasing by 13 percent and, in 1988, by 16 percent.

Between 1988 and 1989, however, enrollees using the benefit increased 66 percent, and covered days escalated almost 175 percent because of the clarification of coverage guidelines and the MCCA cited earlier. In 1990, SNF expenditures fell almost 30 percent due to a decline in covered days per patient. The number of patients served, however, continued to grow. The clarification of coverage guidelines in 1988 kept both utilization and expenditures higher than pre-MCCA levels. Clearly, the dramatic increase in total program expenditures is due primarily to increased utilization rather than to price increases.

Utilization was substantially affected by changes that allowed more enrollees to use the SNF benefit. Higher SNF costs per day accounted for less than

Table 1-10. Medicare Skilled Nursing Facility Utilization and Spending, 1980-1990

Year	Covered Days (In Thousands)	Patients Served* (In Thousands)	Days Per Patient Served	Cost Per Skilled Nursing Facility Day	Total Spending (In Millions)
1980	8,645	257	33.6	\$ 47.54	\$ 411
1981	8,518	251	33.9	52.83	450
1982	8,814	252	35.0	55.82	492
1983	9,314	265	35.1	56.37	525
1984	9,640	299	32.2	58.20	561
1985	8,927	314	28.4	64.64	577
1986	8,160	304	26.8	70.83	578
1987	7,451	293	25.4	84.55	630
1988	11,033	384	28.7	86.65	956
1989	30,046	636	47.2	113.93	3,423
1990	26,000	815	31.9	93.12	2,421
Average annual percent change:					
1980-1985	0.6%	4.1%	-3.3%	6.3%	7.0%
1985-1990	23.8	21.0	2.3	7.6	33.2

* These numbers are for fee-for-service only and may not include health maintenance organization enrollees.

SOURCE: Health Care Financing Administration, Office of the Actuary.

one-third of the growth. A small part of the increased utilization may also have been brought on by PPS, which provided hospitals with an incentive to reduce the length of inpatient stays by transferring patients to SNFs for post-acute care services. In 1984, for example, the number of Medicare patients receiving SNF care rose 12.8 percent over 1983.

Hospital Swing Beds

The Medicare swing-bed program was designed to address the shortage of nursing home beds in rural areas and low occupancy rates in rural hospitals. A swing-bed hospital is a small hospital that can use its beds interchangeably to furnish either acute care services or SNF-type services to Medicare beneficiaries. Swing-bed hospitals are generally allowed to use any number of their acute care beds for SNF-level care.

Hospitals began participating in the swing-bed program in 1982; only hospitals with fewer than 50 beds could qualify. In 1987, the program was extended to rural hospitals with fewer than 100 staffed beds, although additional requirements were placed on these hospitals. The number of hospitals participating in the program has increased every year since its implementation. In 1989, approximately 844 of 1,255 eligible hospitals participated in the program.

The Medicare swing-bed per diem rate, calculated for each state, is based on the state's average Medicaid SNF rate in the previous calendar year. Medicaid SNF payment levels and methods vary from one state to another.

The number of Medicare admissions to swing beds has increased. The average number of covered days for beneficiaries staying in swing beds has consistently been less than 20—substantially lower than that for beneficiaries in skilled nursing facilities.

Swing-bed days account for only a small proportion (about 5 percent) of total SNF care days provided to Medicare beneficiaries. However, the creation of swing beds may have increased access to post-acute care for beneficiaries living in rural areas who may not have such care available close to home. In 1988, there were fewer SNF beds per 1,000 population in areas where swing beds were located compared to those without swing beds.¹²

Home Health Care

Medicare beneficiaries can qualify for home health care benefits if they are confined to their homes and need occasional skilled nursing care for an acute or post-acute condition. Covered home health care services include part-time or intermittent nursing care; physical, occupational, or speech therapy; medical social services; part-time or inter-

mittent services of a home health aide; medical supplies; and durable medical equipment. There is no time limit or prior hospitalization requirement. Program guidelines generally limit part-time or intermittent nursing care to 35 hours per week for up to three weeks. There is no deductible or coinsurance charge for this care. Services must be provided by a Medicare-certified home health agency.

Payment to home health agencies is based on reasonable cost reimbursement subject to certain limits. The limits are set at 112 percent of the mean labor-related and non-labor related per unit costs for each type of service provided by free-standing home health agencies. The limits are applied on an aggregate basis to all visits made by the agency. The payment mechanism for home health care services provides an incentive to control costs for agencies that are above or near the payment cap. Agencies with costs below the cap, however, do not have as much incentive to keep costs down.

Spending for home health care climbed by 440 percent between 1980 and 1990. The largest increase occurred from 1989 to 1990, when spending jumped 47 percent to \$4.4 billion (see Table 1-11). About 1.7 million beneficiaries received home health care services in 1990, an increase of 129 percent over 1980. Intensity of care, as measured by the number of visits per patient served,

has fluctuated throughout the decade. It increased substantially, however, after 1988.

Between 1981 and 1984, beneficiaries served rose at double-digit rates because of a provision in OBRA 1980 that allowed for-profit home health agencies to participate in Medicare in states that do not require their licensing. This change significantly boosted the number of home health agencies participating in the program. There were 5,730 Medicare participating home health agencies in 1990, an increase of 96 percent over 1980.

The latest increase in utilization occurred because of a court case that required HCFA to revise the eligibility and coverage manual, and clarify the rules for part-time or intermittent care criteria. These changes, which became effective in July 1989, reduced provider concerns about retroactive coverage denials of intermittent or part-time care and included a provision for case management services.

The average charge per visit rose 76 percent from 1980 to 1990, only 19 percent more than general inflation. The increase between 1985 and 1990 was actually less than general inflation. Higher spending therefore is due to greater numbers of beneficiaries served and more visits per patient. The average charge per visit accounted for only a small part of the growth in home health expenditures.

Table 1-11. Medicare Home Health Care Utilization and Spending, 1980-1990

Year	Visits (In Thousands)	Patients Served ^a (In Thousands)	Visits Per Patient Served	Spending Per Visit	Spending Per Patient Served	Total Spending (In Millions) ^b
1980	16,322	726	22.5	\$37.19	\$ 836	\$ 817
1981	22,688	948	23.9	41.34	989	1,054
1982	30,628	1,154	26.5	11.50	1,181	1,380
1983	36,898	1,318	28.0	47.35	1,325	1,770
1984	40,422	1,498	27.0	51.46	1,389	2,107
1985	39,449	1,549	25.5	55.49	1,413	2,220
1986	38,000	1,571	24.2	58.21	1,408	2,242
1987	35,588	1,544	23.0	61.71	1,422	2,232
1988	37,100	1,582	23.5	64.10	1,503	2,422
1989	46,173	1,685	27.4	63.78	1,748	3,008
1990	65,985	1,665	39.6	65.62	2,601	4,415
Average annual percent change:						
1980-1985	19.3%	16.4%	2.5%	8.3%	11.1%	22.1%
1985-1990	10.8	1.5	9.2	3.4	13.0	14.7

^a These numbers are for fee-for-service only and may not include enrollees in health maintenance organizations.

^b Includes Part B expenditures.

SOURCE: Health Care Financing Administration, Office of the Actuary.

Changes in coverage and eligibility requirements fueled the growth in home health visits. Greater utilization can also be attributed to expansion in the number of agencies eligible to participate in the program. It is difficult, however, to differentiate the effect of PPS on home health care expenditures due to other changes taking place in the 1980s that may also have influenced spending and use.

Hospice Care

The Medicare hospice benefit was introduced in 1984. Terminally ill Medicare beneficiaries whose life expectancy is six months or less are eligible to receive these services. Hospice care provided to dying persons and their families is supportive rather than cure-oriented. Once a beneficiary chooses to receive the hospice benefit, he or she must waive the right to all other Medicare benefits. Coverage is limited to 210 days, but beneficiaries can receive an additional 90-day period of coverage if they are recertified as terminally ill. Hospice benefits include nursing care, various therapies, medical social services, homemaker-home health services, physicians' services, short-term inpatient care, and patient counseling.

Hospices are paid prospectively for the care they deliver, and the rates vary according to level of care furnished to the beneficiary. They are paid one of four predetermined rates for each day of care they provide: routine home care, continuous home care, inpatient respite care, and general inpatient care.

The number of Medicare-certified hospice providers increased from 108 in 1984 to 825 in

1990. Both spending for hospice care and the number of beneficiaries receiving it have grown markedly (see Table 1-12). Total spending for hospice care was about \$320 million in fiscal year 1990, and there were slightly more than 100,000 hospice admissions. Spending for the benefit is expected to increase dramatically, to more than \$1 billion, by 1995. The hospice benefit, however, substitutes for spending in other parts of Medicare that might occur if the benefit were not available.

The rise in hospice spending is due to higher hospice admission rates and more days of care per admission. The admissions increase reflects the fact that the benefit is new and that more providers are furnishing this care. The number of days per admission climbed from 29 in fiscal year 1984 to 51 in fiscal year 1990, or 76 percent. The cost per patient day rose by only 37 percent over this period, a relatively small amount after accounting for inflation.

Dialysis Facilities

People with ESRD are eligible for all Medicare benefits if they are fully or currently insured under Social Security, entitled to monthly Social Security benefits, or the spouse or dependent child of someone insured under Social Security. About two-thirds of enrollees are under 65. Entitlement to Medicare benefits generally begins in the third month after the month in which renal dialysis is initiated and ends 12 months after dialysis stops. Patients accepting home dialysis training can become entitled to Medicare benefits earlier.¹³

Table 1-12. Estimates of Hospice Program Data, Fiscal Years 1984-1995

Fiscal Year	Hospice Admissions	Days Per Admission	Cost Per Hospice Day	Cost Per Admission	Total Cost (In Millions)
1984	2,200	29	\$62	\$1,800	\$2
1985	11,000	33	66	2,200	15
1986	28,012	37	66	2,442	35
1987	68,721	41	74	3,034	63
1988	84,770	44	74	3,256	90
1989	89,008	48	74	3,470	211
1990	102,359	51	85	4,245	320
1991	112,595	53	93	4,828	465
1992	120,477	55	98	5,270	605
1993	126,501	57	103	5,749	760
1994	132,826	59	108	6,258	920
1995	139,467	61	114	6,811	1,100

SOURCE: Congressional Budget Office estimates, 1984-1989, and baseline projections for 1990-1995.

Program expenditures for ESRD beneficiaries almost doubled over the 1984 to 1989 period, to \$4.4 billion. The program spent an average of \$26,600 per beneficiary in 1989, this includes all Medicare-covered services. About one-fifth of program expenditures are for outpatient dialysis treatment.

Medicare spending for dialysis treatment totaled \$1.2 billion in 1989, a 50 percent increase over 1984. Similarly, the number of enrollees receiving dialysis grew by 49 percent between 1984 and 1989. A total of 129,800 beneficiaries received dialysis treatment in 1990. Facilities that provide dialysis receive a prospectively set rate per treatment. The payment rate per treatment has essentially been unchanged since 1983, so that price changes have not been responsible for increases in Medicare expenditures. The average number of treatments per patient year has also not changed appreciably. The growth in Medicare spending for dialysis, therefore, was due to greater numbers of beneficiaries receiving this treatment.

Other Facilities, Providers, and Suppliers

Medicare recognizes for payment purposes a host of other facilities, providers, and suppliers (see Tables 1-1 and 1-6). Available information shows their proliferation between 1980 and 1990, which may have enhanced beneficiaries' access to care. Data on expenditures, on the other hand, are quite limited except for independent laboratories.

Spending for independent laboratories rose more than 1,000 percent, from \$139 million to \$1.5 billion, between 1980 and 1990. Most of this growth occurred after 1984. Despite higher expenditures, the number of facilities increased by only 42 percent between 1980 and 1990. Since 1984, clinical laboratory services have been paid according to a fee schedule that limits increases in per unit costs for a given procedure. However, it does not control growth related to heavier utilization and greater sophistication of services. These latter two factors, along with increased utilization of independent laboratories rather than hospital outpatient and physicians' offices laboratories, contributed significantly to the dramatic rise in spending.

Nonfacility Providers

Medicare payment for physician services has recently undergone a major change, moving to a fee schedule using relative value scales. Throughout most of the 1980s, however, physician services were paid using a fee-for-service system based on reasonable charges, with each service billed separately. Since the mid-1980s, Congress has increasingly put restrictions on increases in physician payment. Targeted particularly at doctors who did not accept Medicare payment as payment in full, these strategies were designed to encourage physician participation in the Medicare program. They were also aimed at restraining spending growth and limiting beneficiary liability.

Between 1980 and 1990, real spending for physician services rose by 121 percent due to increased utilization and intensity, and higher charges. Between 1980 and 1989, the percentage of beneficiaries receiving physician services paid for by Medicare grew 26 percent. Some of this increase may be explained by the fact that the Part B deductible changed very little over this period.¹⁴

Growth in the number and intensity of services substantially contributed to the higher physician spending over the decade. Between 1980 and 1984, increased volume and intensity contributed about 7 percent annually to this trend. These factors contributed about 6 percent annually to physician expenditures between 1984 and 1988.¹⁵

By contrast, higher physician prices contributed about 9 percent annually to the growth in spending between 1980 and 1984, compared with only about 3 percent between 1984 and 1988.¹⁶ The slower growth in physician payment rates was due to controls placed on physician fee increases and lower inflation in the latter part of the decade.

RELATIONSHIP OF UTILIZATION AND SPENDING TRENDS TO PATTERNS OF CARE

Medicare spending continues to spiral at twice the rate of general inflation, despite attempts to constrain it through changes in Medicare payment and coverage policies. There are many complex and

interacting forces that affect total spending, including the price, overall utilization, and intensity of services; an increase in the number of Medicare beneficiaries; inflation; technological advances; and practice pattern changes. Modifications to Medicare payment and coverage policies also influence spending in ways that were not necessarily intended. The importance of these factors differs substantially among the types of facilities and the services beneficiaries receive.

Expenditures for inpatient acute care hospital services continue to be the largest component of spending, but the rate of growth has slowed partly because of declining admissions. Controls on payment rate increases have also played a substantial role in reducing spending growth. Under PPS, hospitals have an opportunity for financial benefit if they control the services provided throughout the hospital stay, including those furnished within three days of admission. Nevertheless, incentives remain to maximize payment by unbundling services that would have been provided during the inpatient stay. Reduced length of stay and increased utilization of post-acute care service are evidence of this phenomenon.

PPS and other factors that constrained inpatient hospital utilization at the same time helped drive up Medicare spending for other services. For example, the rapid expansion of rehabilitation services is likely related to PPS incentives to shorten inpatient length of stay. The growth in SNF and home health agency use may also partially be attributed to these incentives, although changes in coverage rules probably had a more significant impact.

In other cases, higher spending reflects the interaction of new technological capabilities and changes in policy. Ambulatory surgery is illustrative. In the early 1980s, Medicare began to cover and pay for surgery performed in free-standing units. Technological advances allowed procedures that previously had been performed primarily in inpatient settings, such as cataract surgery and arthroscopy, to be performed on an outpatient basis. This change in setting was encouraged by the Medicare program because it substantially lowered the cost of providing individual services. The result, however, was that more beneficiaries received services, thus boosting spending in outpatient settings.

Post-acute care increasingly can be delivered not only in skilled nursing facilities, but also in rehabilitation hospitals and units and through home health care providers. Similarly, certain surgical procedures can be provided in inpatient and outpatient hospital units, in free-standing ambulatory surgical centers, and in physicians' offices. The availability of multiple facilities and sites of service creates opportunities to meet the needs of a diverse population of enrollees in an appropriate fashion. However, multiple settings contribute to the inability to contain total health care spending and to ensure appropriate patterns of care across an entire episode of illness.

Changes in coverage and benefits also exert an influence on the growth in Medicare spending. This is particularly evident in the case of SNF and home health agency services. Recent changes clarifying coverage requirements for these services are major contributors to higher utilization and spending.

Other considerations in the context of cost control are the various payment methods employed across facilities and sites, even for essentially similar services. Because of this, cost control efforts are fragmented and generally are directed only at constraining the unit price of a service rather than at checking overall utilization and total expenditures. The Medicare program implemented PPS to control the costs of services provided during an inpatient hospital stay, but has not developed similar controls for other sites of care. This may help explain the faster growth in spending observed in other parts of the program. Multiple payment methods also contribute to the inability to ensure the most appropriate pattern of care across settings.

Many of the payment strategies for controlling expenditures in other settings have focused on spending per unit of service. But these approaches do not constrain growth in intensity or volume of services provided. Although Medicare SNF payment methods can be used to control the price per SNF day, for instance, they do not control the number of beneficiaries receiving care or the number of days provided. The Medicaid program and state efforts to control the number of facilities, as well as the limited nature of the Medicare SNF benefit, probably have much more of an impact on overall Medicare spending for these services. Other ser-

vices, such as home health and clinical laboratories, are less subject to constraints on volume.

While maintaining or even improving the package of services furnished during an episode of care, Medicare's efforts to control growth in spending thus affect and are affected by the diversity of practitioners and suppliers. Further, patterns of care are shaped not only by clinical decisions and technological capabilities, but also by payment methods and service availability. The Commission's goals in modifying payment methods consider how all these factors affect the broader health care delivery system.

Goals of Medicare Payment Methods

ProPAC believes that Medicare's payment methods should result in consistent financial incentives across all treatment settings. These methods should reward productivity improvements and discourage unnecessary intensity. To achieve this, system modifications should account for the different types of providers and facilities that may be involved in the services delivered during an episode of care.

In addition, the payment systems should promote appropriate quality of care throughout an episode of illness, from ensuring access to necessary services to coordinating the array of services provided. Clearly, factors other than Medicare's payment methods have a major impact on quality and access. These include licensure and certification requirements, health care personnel training, and policies of other payers, to name a few. To the extent that Medicare payment policies encourage coordination of services over an episode, they should promote these policy goals.

Further, the Commission believes that individual providers should be adequately compensated for

the services they furnish. Inadequate payment could have serious implications for access to and quality of care. ProPAC is mindful, however, of the current fiscal environment and the Federal budget deficit: Rising health care costs are a grave concern, and payment policy changes need to address this issue. Achieving the balance between appropriate payment levels and cost containment presents a significant challenge in efforts to reform Medicare's payment methods.

Commission Payment Reform Activities

Since its inception, the Commission has been involved in payment reform for inpatient hospitals and excluded facilities. This mandate was recently expanded to include hospital outpatient facilities, skilled nursing facilities, home health agencies, and dialysis facilities. ProPAC will incorporate the goals discussed above into its analyses and recommendations on payment reform for this diverse group.

In its forthcoming March report on hospital outpatient payment policies, ProPAC offers recommendations on an incremental approach to fully prospective payment methods for outpatient services. The Commission believes that for all outpatient facilities and providers, prospective payment is an appropriate means to achieve consistent financial incentives for productivity and the right level of intensity and cost containment. Along with policy changes, adequate quality assurance mechanisms also need to be developed. In March, ProPAC will also issue a preliminary report on SNF payment. Although this report will not recommend a specific payment method, it will provide information and a framework for achieving the same goals with SNF payment reform. The Commission's activities on the other facilities under its expanded mandate will be directed toward these ends.

Notes to Chapter 1

1. Health Care Financing Administration estimate.
2. Health Care Financing Administration, Office of Research, unpublished data from a forthcoming report, September 25, 1991.
3. SMG Marketing Group, *Freestanding Outpatient Surgery Center Directory and Report* (Chicago, IL: SMG Marketing Group, 1991).
4. Cancer hospitals have been excluded from PPS only since 1989.
5. For more information, see the Commission's forthcoming June 1992 report to Congress on excluded providers.
6. For more information, see the Commission's March 1992 report to Congress on hospital outpatient payment.
7. American Hospital Association, *Hospital Statistics*, 1990-1991 edition (Chicago, IL: AHA).
8. Ibid.
9. For more information, see the Commission's March 1992 report to Congress on skilled nursing facility payment.
10. During 1989, when the Medicare Catastrophic Coverage Act was in effect, SNF services were covered for 150 days per calendar year and did not require a prior hospitalization. In addition, coinsurance of \$25.50 was required only for the first eight days of coverage.
11. In April 1988, HCFA clarified the SNF coverage guidelines. This resulted in an expansion of Medicare SNF utilization; previously, many beneficiaries did not apply or were not encouraged to apply for Medicare coverage because of the possibility of retroactive denial of coverage. The MCCA eliminated the three-day prior hospitalization rule, expanded the allowable days of coverage, and modified the coinsurance policy, resulting in increased utilization of the Medicare SNF benefit.
12. Unpublished ProPAC analysis.
13. For more information, see the Commission's forthcoming June 1992 report to Congress on dialysis facility payment.
14. Beneficiaries do not start receiving Medicare Part B benefits until they have reached the Part B deductible amount, which was \$75 from 1983 to 1989 and increased to \$100 in 1990. Only enrollees who exceed the Part B deductible are counted as using physician services.
15. Physician Payment Review Commission, *Fee Update and Medicare Volume Performance Standards for 1992*, Report No. 91-3, May 15, 1991.
16. Ibid.

Chapter 2

Recommendations

Chapter 2

Recommendations

The Prospective Payment Assessment Commission (ProPAC) was created by Congress in 1983. Its primary responsibility then was to analyze issues and make recommendations for updating and improving the Medicare prospective payment system (PPS). Over time, Congress has expanded ProPAC's responsibilities to include analyzing current payment policies for all facility services furnished to Medicare beneficiaries and developing policies for the future.

These expanded responsibilities include payment for hospital outpatient services, services furnished by skilled nursing facilities (SNFs) and home health agencies, and dialysis services for end-stage renal disease (ESRD) patients. The Congress has also requested that ProPAC examine and report on broader issues regarding the effectiveness and quality of health care delivery in the United States. The Commission, however, continues to devote a substantial amount of effort to updating and improving payment for PPS hospitals and excluded hospitals and distinct-part units.

From 1985 through 1990, ProPAC's recommendations were delivered to the Secretary of Health and Human Services (HHS). Following the enactment of the Omnibus Budget Reconciliation Act (OBRA) of 1990, the Commission's report and recommendations are now made directly to Congress. The Secretary, however, is still required to consider ProPAC's recommendations and respond to them in the annual notice of PPS rulemaking published in the *Federal Register*.

ProPAC's analyses and decisionmaking are guided by a set of principles that were initially based on the goals of PPS, but which also are applicable to other facility services. These principles provide the foundation for the Commission's recommendations. They are:

- Ensuring beneficiary access to high-quality health care;
- Encouraging productivity and long-term cost-effectiveness;
- Facilitating innovation and appropriate technological change;
- Promoting equity in the distribution of payments;
- Maintaining stability for providers, consumers, and third-party payers; and
- Making decisions based on reliable, timely data and information.

Along with these principles, the Commission is mindful of the current fiscal environment. Rising health care costs and their effect on the Medicare trust funds and the Federal budget are concerns the Commission takes into account with each recommendation. Moreover, budgetary pressures intensify the need to address distributional and technical payment issues that may affect access and quality of care furnished to Medicare beneficiaries.

ProPAC's recommendations reflect the collective judgment of the 17 Commissioners. Some of the subjects of these recommendations are repeated every year, such as the annual update. Others are either modifications of previous recommendations or cover new issues. All incorporate recent research findings. This year, in addition to its specific recommendations, the Commission has highlighted several areas of concern. Work on these and other issues continues.

RECOMMENDATIONS FOR FISCAL YEAR 1993

The Commission's recommendations and concerns fall into six areas:

- Updating PPS payments,
- Adjusting the payment system,
- Updating and adjusting payments to PPS-excluded hospitals and distinct-part units,
- Updating payments to dialysis facilities,
- Improving hospital outpatient payment policy, and
- Improving skilled nursing facility payment policy.

Updating PPS Payments

The Commission is mandated by law to recommend to the Congress each year the appropriate update to the inpatient hospital payment rates under PPS. As required, ProPAC considers several factors in developing its annual update recommendation: the hospital market basket index (which reflects the prices of resources used by hospitals in providing inpatient care), scientific and technological advances, hospital productivity, the quality of health care, and long-term cost-effectiveness. The Secretary of Health and Human Services is required to take the Commission's recommendation into consideration in developing his update recommendation. The actual update is determined by Congress.

In OBRA 1990, the PPS update was established for each fiscal year through 1995. For fiscal year 1993, the update is set equal to the change in the hospital market basket index minus 1.55 percentage points for urban hospitals, and the change in the index minus 0.55 percentage points for rural hospitals. Even though the fiscal year 1993 update has been set by law, ProPAC has continued to follow its approach of examining the individual factors that together determine the appropriate update to the PPS payment rates. The Commission believes that this approach will result in an update that is sufficient to maintain Medicare beneficiaries' access to

high-quality care while encouraging hospital efficiency in providing such care.

In addition to the update to the PPS payment rates, the Commission in this report recommends an update for rates derived from hospital base-year costs. These rates may be used in place of the PPS rates for sole community hospitals and small rural Medicare-dependent hospitals. ProPAC also considers the update for the Federal payment rate under the prospective payment system for capital, which became effective in fiscal year 1992. The update for facilities currently excluded from PPS is addressed in a later section of this chapter.

Recommendation 1: Amount of the Update Factor for PPS Hospitals

For fiscal year 1993, the PPS standardized payment amounts should be updated to account for the following factors:

- The projected increase in the Health Care Financing Administration (HCFA) PPS market basket index, currently estimated at 4.5 percent;
- An upward adjustment of 0.2 percentage points, to reflect the difference between the ProPAC and HCFA market baskets;
- A correction for substantial error in the fiscal year 1991 market basket forecast of -0.8 percentage points;
- A net discretionary adjustment factor of zero; and
- A net adjustment of -0.7 percentage points for case-mix change.

In addition, a positive adjustment of 0.85 percentage points for hospitals in rural areas and a negative adjustment of 0.15 percentage points for hospitals in large urban and other urban areas should be made to reflect a continuation of the phase out of the differential in the standardized amounts between rural and other urban hospitals.

ProPAC's recommendation would result in an estimated average update factor of 3.2 percent for fiscal year 1993, with an increase of 3.05 percent for urban hospitals and 4.05 percent for rural hospitals. This recommendation reflects the Commission's judgment about the appropriate increase in the level of PPS payment rates. Since it is based on current projections of the fiscal year 1993 increase in the market basket index, the effective value of ProPAC's update factor recommendation may be modified as more current forecasts become available. The components of ProPAC's update factor recommendation are summarized in Table 2-1, and a discussion of each of those components follows.

It should be noted that the increase in average per case payments to hospitals in each year is greater than the PPS update. This is because increases in the Medicare case-mix index (CMI) result in proportional increases in hospital payments. Future changes in case mix are difficult to

project; however, on the basis of currently available data, ProPAC estimates that the CMI will increase by 2.3 percent in fiscal year 1993. Based on the Commission's recommendation of a 3.2 percent average update, the average increase in per case payments would be about 5.6 percent.

PPS Market Basket Increase Forecast and Forecast Error Correction—The forecasted increase in the market basket index is the expected change in the prices paid by hospitals for the resources used during a typical hospital stay. This forecast is the reference point used in updating the PPS payment rates. The current forecast is for a 4.5 percent increase in HCFA's PPS market basket index during fiscal year 1993.

In its March 1990 *Report and Recommendations to the Secretary, U.S. Department of Health and Human Services*, ProPAC proposed modifications to the market basket used by HCFA. Although

Table 2-1. Recommended PPS Update Factor for Fiscal Year 1993

Components of the Update

Components applied to all hospitals:

Fiscal year 1993 HCFA PPS market basket forecast*	4.5%
Adjustment for difference between HCFA and ProPAC market baskets*	0.2
Correction for fiscal year 1991 forecast error	-0.8
Components of discretionary adjustment factor	
Scientific and technological advancement allowance	1.0
Productivity adjustment	-1.0
Net discretionary adjustment factor	0.0
Adjustments for case-mix change (fiscal year 1992)	
Total DRG case-mix index change	-2.5
Real across-DRG case-mix change	1.5
Within-DRG case-complexity change	0.3
Net adjustment for case-mix change	-0.7

Additional adjustments to the standardized amounts:

Adjustment for large urban areas	-0.15
Adjustment for other urban areas	-0.15
Adjustment for rural areas	0.85

Total Update Factor

Overall average	3.2
Large urban	3.05
Other urban	3.05
Rural	4.05

* Market basket forecast provided by the Health Care Financing Administration, Office of the Actuary, December 1991. The market basket forecast is subject to change as more current forecasts become available.

HCFA adopted most of these modifications, it did not incorporate the key provision that increased the weight of internal hospital wages in the computation of the market basket index. The Commission believes that the market basket as currently constructed does not adequately recognize the unique characteristics of the hospital labor market.

Since the PPS update for fiscal year 1993 is legislated relative to a market basket that HCFA would implement, HCFA's market basket is used as the basis for the update. ProPAC's update recommendation takes this into account by making an adjustment of 0.2 percentage points to account for the estimated effect of the modifications it believes are justified.

A forecasted market basket increase of 5.2 percent was used to set payments in fiscal year 1991. The actual market basket increase, however, was 4.4 percent. The update for fiscal year 1991 was thus set 0.8 percentage points higher than if the actual market basket increase had been known at the time.

The Commission believes that a correction for substantial error in market basket forecasts is an important part of its update framework. This correction protects both hospitals and the Federal government by adjusting the base payment rates so that the effects of past forecast errors (both positive and negative) are removed. Therefore, ProPAC's update recommendation also includes a -0.8 percentage point adjustment for fiscal year 1991 market basket forecast error.

Discretionary Adjustment Factor—The discretionary adjustment factor (DAF) incorporates considerations related to scientific and technological advancement and hospital productivity improvement, as provided in the statute establishing PPS. While the market basket index measures the cost of the resources used during a typical hospital stay, the components of the DAF reflect changes in the mix of those resources over time. In general, scientific and technological advancement accounts for the use of new resources that may increase costs; productivity accounts for changes in resource use that may decrease costs.

The scientific and technological advancement allowance is a future-oriented policy target. It provides additional funds for hospitals to adopt quality-enhancing health care advances, even when they

increase costs. To develop an informed judgment as to the appropriate level of this allowance, ProPAC each year sponsors a study that examines a set of the most important new cost-increasing technologies and scientific developments. For fiscal year 1993, these technologies are expected to increase Medicare operating costs by 0.9 percent. However, the cost-increasing effects of "small-ticket" technologies and changes in practice patterns are not included in this estimate. Given these considerations, the Commission believes that 1.0 percent is an appropriate level for the scientific and technological advancement allowance.

The productivity adjustment is also a future-oriented target. The Commission believes it is reasonable to expect hospitals to achieve productivity improvements during fiscal year 1993 comparable to those achieved in other sectors of the economy. The recommended adjustment of -1.0 percent is based on ProPAC's determination that hospital productivity should increase by 2.0 percent, and that the savings from such improvement should be shared equally by hospitals and the Medicare program.

The Commission therefore concludes that the positive scientific and technological advancement allowance and the negative productivity improvement adjustment should offset each other. ProPAC believes that it is appropriate for the costs of scientific and technological advancement to be financed by expected productivity gains, to provide an incentive for hospitals to strive for productivity improvement as they adopt new technologies. (See Appendix A for more information on the DAF.)

Adjustments for Case-Mix Change—For fiscal year 1993, the PPS update should be reduced by 0.7 percentage points to account for the net effect of case-mix change during fiscal year 1992. This adjustment reflects:

- A 2.5 percentage point reduction for the estimated change in the CMI;
- A positive allowance of 1.5 percentage points for real case-mix change across diagnosis-related groups (DRGs); and
- A positive allowance of 0.3 percentage points for within-DRG case-complexity change.

Adjusting for these factors allows payments to increase due to real changes in the resources required to treat an average Medicare patient. At the same time, it removes the effect of changes in medical record documentation and coding practices that are unrelated to patient resource requirements (also referred to as upcoding).

The annual rate of increase in the CMI has generally declined over time. This pattern reflects a dramatic change in the distribution of patients across DRGs (due both to treatment patterns and to upcoding) when PPS was implemented, followed by a gradual settling toward a new equilibrium. This trend, however, has been interrupted when revisions to the payment system created new opportunities for upcoding—particularly in fiscal year 1988, when the criteria for assigning patients to DRGs were changed.

Each year, ProPAC estimates the increase in the CMI for the previous year, based on available data on the trend in prior years and expectations about the effects of any DRG changes that may have been implemented. ProPAC's estimate for fiscal year 1991 indicates that changes in the DRG assignment rules led to another acceleration in the CMI. ProPAC's estimate of the increase in the CMI for fiscal year 1991 is 2.7 percent. In fiscal year 1992, DRG changes and increases in the numbers of fields for entering diagnosis and procedure codes on the Medicare bill may provide additional opportunities for upcoding. Nonetheless, the Commission expects that the increase in the CMI will be 2.5 percent in fiscal year 1992, lower than in the previous year.

Real CMI change is that portion related to actual increases in patient resource requirements across DRGs. ProPAC's estimate of real CMI change takes into account previous studies that apportioned increases in the CMI into real and upcoding components. These studies indicate that real CMI change in past years has been in the range of 1.5 percent to 1.6 percent. In the Commission's judgment, 1.5 percentage points of the 2.5 percent increase in the CMI for fiscal year 1992 will be related to real changes in patient resource requirements.

ProPAC's estimate of within-DRG case-complexity change takes into account information

from a series of studies, in which a more detailed patient grouping mechanism is applied to Medicare data for discharges within each DRG. As with the CMI, the rate of increase in case complexity tends to decline over time. The most recent estimates are that case complexity rose by 0.6 percent in fiscal year 1989 and by 0.5 percent in fiscal year 1990. On the basis of this trend, ProPAC estimates that case-complexity change in fiscal year 1992 will be 0.3 percent.

During the first eight years of PPS, CMI change generated payment increases that were almost equal to those resulting from the annual updates and all other payment policies combined. Given the magnitude of this factor and its failure to diminish as much as expected, it remains an important topic on the Commission's analytic agenda.

Differential Adjustments to the Standardized Amounts—ProPAC supports the provisions in OBRA 1990 that eliminate the difference between the standardized payment amounts for hospitals in rural areas and for those in other urban areas (metropolitan areas with fewer than one million people). This is to be accomplished by fiscal year 1995 by providing higher updates to rural hospitals. Consistent with current law, the Commission is recommending that the PPS update for rural hospitals be 1 percentage point higher than that for urban hospitals. The overall average update of 3.2 percent based on ProPAC's PPS update framework would be maintained by increasing the rural update by 0.85 percentage points, and decreasing the large urban and other urban hospital updates by 0.15 percentage points.

Since the beginning of PPS, Medicare payments have been higher relative to costs for urban hospitals than for rural hospitals. This is primarily the result of two factors. Urban hospitals have benefited more from the PPS payment adjustments—particularly the effects of CMI change and the indirect medical education (IME) and disproportionate share (DSH) adjustments. In addition, rural hospitals have had large declines in inpatient volume, raising fixed costs per case.

However, as indicated in ProPAC's October 1991 report to Congress, *Rural Hospitals Under Medicare's Prospective Payment System*, several recent policy changes have improved the relative

performance of rural hospitals under PPS. This trend promises to continue. The Commission will monitor and analyze the further effects of these policies as additional data become available.

Recommendation 2: Amount of the Update Factor for Hospitals Paid on the Basis of Hospital-Specific Rates

The Commission believes that payments based on hospital-specific base-year costs for sole community hospitals and for small rural Medicare-dependent hospitals should be updated by the same factor that applies to the PPS rate for rural hospitals.

This recommendation would result in an update to the hospital-specific rates of 4.05 percent for fiscal year 1993, consistent with the Commission's recommendation on the PPS update. Since the update is based on current projections of the fiscal year 1993 increase in the market basket index, its effective value may be modified as more current forecasts become available.

OBRA 1989 provides that certain hospitals be paid on the basis of the PPS rate, their own 1982 base-year costs updated to the current year, or their updated 1987 base-year costs, whichever would yield the largest payment. Two groups of hospitals qualify for this special treatment: sole community hospitals, which meet certain criteria based on distance from other hospitals or market share; and small rural Medicare-dependent hospitals, which are rural hospitals with fewer than 50 beds and at least a 60 percent Medicare share of total discharges or inpatient days. The provision for small rural Medicare-dependent hospitals applies only to cost reporting periods ending on or before March 31, 1993.

Current law requires that the hospital-specific rates for these hospitals be updated at a rate equal to the increase in the PPS hospital market basket index. PPS rates, however, are to be updated by less than this amount in fiscal year 1993. This discrepancy means that hospitals with relatively high base-year costs (above the PPS rate) would receive a larger update than those with relatively low base-year costs. High-cost hospitals would therefore be twice advantaged. They would receive both their

higher base-year cost rate and a higher update to those rates compared with lower-cost hospitals.

The update applied to the hospital-specific rates for sole community hospitals and small rural Medicare-dependent hospitals should be equal to that applied to the PPS rates under which the same hospitals would be paid. This option provides relief for hospitals with high base-year costs due to their special circumstances by raising their payment base. However, once the payment base is raised, it subjects them to the same payment constraints deemed appropriate for all other comparable PPS hospitals.

Recommendation 3: Updating Capital Payment Rates

The Commission recommends that a single update factor be developed for adjusting PPS operating and capital payment rates. The update framework should be consistent with that currently used by ProPAC to develop the PPS operating rate update recommendation, and should be put into use for fiscal year 1994.

Medicare's capital payment method was changed from a cost basis to a prospective per case payment beginning in fiscal year 1992. The new capital payment method will be phased in over a 10-year transition period. During the transition, an increasing portion of capital payments will be based on the national average payment rate.

The Secretary plans to update the base capital payment rate for fiscal year 1993 using the average per case increase in Medicare inpatient hospital capital costs in fiscal years 1989 and 1990, adjusted for case-mix change. The fiscal year 1994 and 1995 capital updates are to be based on a similar methodology. Starting in fiscal year 1996, the Secretary will determine the capital update factor using a framework similar to that used for updating PPS operating payment rates. Because the statute requires that Medicare capital payments be budget neutral with respect to 90 percent of costs through fiscal year 1995, the proposed updates will affect the base payment rate, but not total capital payments. Beginning in fiscal year 1996, however, the resulting base payment rate will determine the capital payments each hospital receives.

The Commission believes that ultimately there should be one payment for hospital inpatient operating and capital expenses. ProPAC understands that it is not possible to combine operating and capital payments until the transition to fully prospective capital payment is complete. Despite the separate payment rates, hospitals do not distinguish between their operating and capital payments. Operating payments may be used to defray capital shortfalls and vice versa. Thus, hospitals should face the same financial incentives for operating and capital decisions. Therefore, the Secretary should move to a single update approach for inpatient operating and capital payment rates as soon as possible.

The Commission believes that a formula-based update, consistent with that applied to the PPS update, should be used before fiscal year 1996. In ProPAC's view, the use of past cost increases to set future payment rates is inappropriate. This would incorporate past cost increases that may reflect inefficient capital spending behavior into the fiscal year 1996 base. Capital payments should be set at a level that reflects efficient capital spending per case. This would be accomplished by incorporating the update for capital payment rates into the current PPS update framework.

ProPAC therefore recommends the development and use of an update framework that combines capital and operating payments for fiscal year 1994. Like the operating update currently used by ProPAC, the new combined update framework should incorporate a market basket to measure changes in prices, as well as adjustments for scientific and technological advances, productivity, and case-mix change. This would ensure that updates to both operating and capital base payment rates reflect increases in the cost of the goods and services that hospitals require to produce inpatient hospital care efficiently.

Adjusting the Payment System

The PPS payment system adjusts hospital payments in several ways to account for factors such as the level of teaching activity, wage rates, and case complexity, which may legitimately affect hospital costs. These adjustments are important for providing a fair level of payment to hospitals depending on the circumstances they face.

As part of its mandate, the Commission examines the distribution of PPS payments across hospitals and makes recommendations concerning the various adjustments to the payment system. ProPAC considers adjustments that are made both at a hospital level and at a case level. In this year's report, the Commission makes recommendations concerning the indirect medical education and disproportionate share adjustments, improvements in the definition of labor markets, transfer payment policy, hemophilia clotting factor, epilepsy centers, and the program establishing essential access community hospitals (EACHs) and rural primary care hospitals (RPHs). In addition, the Commission makes statements concerning DRG refinement, and Peer Review Organizations (PROs) and the quality of care.

Recommendation 4: Level of Indirect Medical Education and Disproportionate Share Adjustments to PPS Operating Payments

The Commission recommends that the indirect medical education adjustment to PPS operating payments be reduced from its current level of 7.7 percent to 7.0 percent for fiscal year 1993. This reduction should be implemented in a budget neutral fashion, with the anticipated decrease in indirect medical education payments returned to teaching hospitals that are designated as disproportionate share providers through a corresponding increase in their disproportionate share adjustment percentages.

The IME adjustment is intended to recognize the higher costs teaching hospitals incur in treating Medicare patients. These costs have been attributed to caring for patients with more severe or complex illnesses, providing a broader scope of more intense services, and using a costlier mix of staff.

ProPAC annually estimates the relationship between teaching intensity and adjusted Medicare operating costs per discharge. The adjustments control for differences in costs that are accounted for by other PPS payment factors, such as geographic differences in the PPS base payment amounts, the local area wage index, the hospital's Medicare case-mix index, and outlier payments for extremely long or costly cases. The most recent analysis was based on cost data from the sixth year of PPS and pay-

ment rules for fiscal year 1992. The results indicate that, on average, a 10 percent difference in teaching intensity is associated with a 5.7 percent difference in Medicare operating costs per discharge.

The Commission recognizes that, since PPS began, the Medicare program has more than adequately compensated teaching hospitals for the costs of treating Medicare patients. The current 7.7 percent IME operating payment adjustment is substantially higher than the empirical estimate of 5.7 percent indicated by the most recent analysis. Moreover, PPS operating margins consistently have been higher for teaching hospitals than for non-teaching hospitals. PPS margins have been especially high for major teaching hospitals (that is, those with the highest levels of teaching intensity).

However, the overall financial performance of major teaching hospitals has been poor relative to other hospitals. Major teaching hospitals have had lower total margins than other hospital groups. The Commission is concerned that the continued operation of these hospitals and the fulfillment of their unique role in the provision of health care might be impaired by a substantial immediate reduction of Federal support.

ProPAC believes that the Medicare program's responsibility to its enrollees is broader than merely paying for Medicare operating costs. This responsibility includes the maintenance of access to high-quality health care, which might be affected adversely if the poor financial condition of major teaching hospitals were to worsen. A sharp reduction of the IME adjustment might have that undesirable effect.

Given these considerations, the Commission believes that a gradual reduction of the IME adjustment is a prudent course of action. ProPAC would reduce the adjustment by approximately one-third of the difference between the current level and the Commission's estimate of 5.7 percent each year for three years. Based on the current estimate of the relationship between teaching intensity and Medicare operating costs, the IME adjustment would be reduced to 6.3 percent in fiscal year 1994 and to 5.7 percent in fiscal year 1995. This approach recognizes as an ultimate objective the use of the IME adjustment to compensate appropriately for differences in Medicare costs that are attributable

to differences in teaching intensity. ProPAC will continue to examine the financial status of teaching hospitals to avoid any deleterious effects on access to high-quality care for Medicare enrollees.

The DSH adjustment is designed to ensure that Medicare beneficiaries have access to high-quality health care at hospitals that treat a large share of low-income patients. Both access to care and the quality of the care provided by these hospitals might be affected adversely if their generally poor financial condition were to worsen. The Commission believes that the Federal government and the Medicare program have a broad responsibility to avoid that situation.

In recent analyses, ProPAC has compared several methods of measuring the burden of uncompensated care and distributing disproportionate share payments. These analyses indicate that, except for hospitals with the highest uncompensated care loads, the current DSH adjustment mechanism distributes payments reasonably proportional to the amount of uncompensated care provided. However, the hospitals that provide the largest share of uncompensated care receive a low share of DSH payments relative to that burden.

ProPAC's analyses indicate that DSH hospitals with teaching programs tend to have much lower total margins than other hospital groups (see Table 2-2). The Commission is concerned that the unique role of these hospitals in the provision of high-quality health care to low-income patients, including low-income Medicare patients, might be adversely affected if their financial condition were to worsen.

ProPAC analyzed the effects of several alternatives for distributing the savings that would result from a reduction of the IME adjustment. Redistributing these savings through an increase in the DSH adjustment for hospitals with teaching programs would greatly reduce the disparity in total margins across hospital groups. The Commission therefore recommends that the IME adjustment be exactly offset by corresponding increases in DSH payments for teaching hospitals designated as disproportionate share providers.

As noted earlier, changes in the IME and DSH adjustments should be considered in the context of their interactions with other components of the

Table 2-2. Simulated Aggregate Total Margins, in the Sixth Year of PPS, Using Fiscal Year 1992 Payment Rules with Alternative Adjustments (In Percent)

Adjustment Alternative	Payment Adjustment Category			
	IME Only	DSH Only	IME and DSH	Neither
Fiscal year 1992 payment rules, including a 7.7 percent indirect medical education adjustment	4.2%	4.0%	2.8%	4.5%
Fiscal year 1992 payment rules, with a 5.7 percent indirect medical education adjustment and savings redistributed to:				
Disproportionate share teaching hospitals	3.7	4.0	3.2	4.5
All disproportionate share hospitals	3.7	4.7	2.9	4.5
All hospitals	4.0	4.3	2.5	4.7
Fiscal year 1992 payment rules, with 5.7 percent indirect medical education adjustment and no redistribution of savings	3.7	4.0	2.2	4.5

SOURCE: ProPAC analysis of Medicare Cost Reports and MedPAR file data from the Health Care Financing Administration.

payment system and their effects on PPS payments, as well as hospitals' overall financial status. The impact on the quality of care and access to that care should also be considered. In general, any change in Medicare payment policy must be evaluated in terms of its effect on the health care system as a whole.

In the coming year, ProPAC will continue to examine the level and structure of the IME and DSH adjustments, as well as other factors that affect hospitals' payments, costs, and financial condition. The distribution of PPS and total margins and the other effects of potential changes in the IME and DSH adjustments will also be studied. ProPAC's most recent analysis is described in a technical report, *Indirect Medical Education and Disproportionate Share Hospital Payment Adjustments* (March 1992).

Recommendation 5: Consistency of Indirect Medical Education and Disproportionate Share Adjustments to PPS Capital and Operating Payments

The Commission recommends that the same level of indirect medical education and disproportionate share payment adjustments be applied to both operating payments and the prospective component of capital payments, beginning in fiscal year

1994. Further, ProPAC believes that the methods of determining these adjustments to PPS operating payments should also be applied to capital payments. Therefore:

- The measure of teaching intensity used for the indirect medical education adjustments should be defined in terms of the ratio of residents per bed, and
- The criteria for designation as a disproportionate share provider should be based on urban or rural location and number of beds.

These changes would better reflect the policy objectives of the Congress in defining and setting the levels of the payment adjustments. They would also be consistent with the principle of incorporating capital into the PPS rate.

Through fiscal year 1991, PPS operating payments were determined prospectively, while capital costs were paid on a pass-through basis. Therefore, the IME and DSH adjustments were applied only to PPS operating payments. In fiscal year 1992, capital payments began a 10-year transition to a fully prospective payment system. The prospective component of PPS capital payments also includes adjustments for teaching and disproportionate share

hospitals. However, both the definitions and the levels of these adjustments differ from the IME and DSH adjustments to operating payments.

A single IME adjustment applied to both operating and capital payments requires a consistent definition of teaching intensity. The measure of teaching intensity used for the IME adjustment for operating payments is based on the number of residents per available bed. By contrast, the number of residents per patient is used to define teaching intensity for capital payments.

The two measures of teaching intensity are similar for hospitals with high occupancy rates, but the per patient measure is much higher for hospitals with low occupancy rates. Therefore, basing the IME adjustment on the per patient measure would tend to reward low occupancy teaching hospitals at the expense of high occupancy teaching hospitals. The Commission believes this result is inconsistent with the PPS objective of encouraging the efficient provision of health care services.

Furthermore, ProPAC's analyses indicate that use of the per patient measure would substantially reduce payments to high occupancy major teaching hospitals in urban areas, which have a large share of low-income patients and low total margins. By contrast, the per patient measure would substantially increase payments to low occupancy (often suburban) hospitals, with smaller teaching programs, a smaller share of low-income patients, and higher total margins. Because the per patient measure would both produce inappropriate incentives and reduce IME payments to the teaching hospitals with the greatest need for Federal support, the Commission believes that the measure of teaching intensity for IME adjustments to both operating and capital payments should be based on the ratio of residents to available beds.

The IME adjustment applied to operating payments is based on an analysis of the relationship between teaching intensity and operating costs per Medicare case. The IME adjustment applied to capital payments is based on the relationship between teaching intensity and combined operating and capital costs per Medicare case. In the longer term, the Commission believes that a single IME adjustment applied to both operating and capital payments should be based on the combined measure. As with

the current operating adjustment, the level should be set to reflect not only the empirical relationship, but also the broader policy objectives that have been incorporated by the Congress.

The eligibility criteria for the DSH adjustments to operating and capital payments also differ. The operating adjustment is based on urban or rural location and the number of beds, as well as the hospital's low-income share. However, only urban hospitals with at least 100 beds are eligible for the DSH capital payment adjustment. Thus, many hospitals that receive the DSH operating payment adjustment are not eligible for the capital payment adjustment.

In addition, the two DSH adjustments use different distribution formulas: The DSH operating payment adjustment is graduated, and directs more payments to hospitals with the highest shares of low-income patients than the DSH capital payment adjustment. ProPAC compared several alternative methods for distributing DSH payments and found that, of the alternatives considered, the graduated DSH operating payment formula distributes payments that most closely correspond to the broader objectives of the policy.

The Commission therefore recommends that the eligibility criteria and adjustment formulas developed for DSH operating payment adjustments be applied to capital payments. In anticipation of a fully prospective system for both operating and capital payments, ProPAC has recommended that consistent update factors be implemented in fiscal year 1994. The Commission also recommends that the IME and DSH adjustments applied to the prospective component of capital payments should be the same as the adjustments applied to operating payments, effective in fiscal year 1994.

Recommendation 6: Improvements in Labor Market Definitions

The Commission believes that the current PPS labor market definitions need to be improved or replaced as soon as possible. Suitable alternative definitions, however, are not immediately available. In cooperation with the American Hospital Association and the Health Care Financing

Administration, ProPAC is developing alternative labor market definitions that may alleviate many of the current problems. On the basis of this effort, the Commission hopes to be able to recommend substantially revised labor market definitions for fiscal year 1994.

Under PPS, an area wage index is used to adjust hospitals' DRG payment rates per discharge to reflect variations in the wage rates hospitals must pay for labor in different geographic areas. The index measures the level of average hourly compensation for hospital workers in each labor market area relative to the national average. Under current law, changes in the wage index are required to be budget neutral. Therefore, changes in the wage index do not affect aggregate payments to hospitals under PPS. However, the index is a key determinant of the distribution of payments among hospitals because of its impact on each hospital's base payment rate. A 10 percent difference in the wage index for a hospital's labor market area will lead to about a 7 percent difference in its total PPS payments.

Since the inception of PPS, the wage index has been constructed using labor market areas based on county boundaries. Urban labor market areas have been defined by metropolitan statistical areas (MSAs). Each MSA includes a set of contiguous, economically integrated counties, generally incorporating a central city and its surrounding suburbs. A single statewide rural labor market area has been defined for each state, including all counties in the state that are not in an MSA.

The use of labor market areas based on county boundaries has created two important problems. First, large differences in wage index values often exist between nearby hospitals located on either side of such boundaries. In fiscal year 1991, for example, the wage index for hospitals located in the Joliet, Illinois, MSA was 33 percent higher than that for nearby hospitals located in adjacent rural counties. Differences of somewhat lesser magnitude often exist among adjacent MSAs and among adjacent rural labor market areas in neighboring states.

In addition, many of these labor markets cover extensive geographic areas that include a large and diverse population of hospitals. This occurs

because of the vast size of many counties, especially in the West. Hourly compensation for hospital workers often varies markedly among the hospitals within such areas. Consequently, many hospitals are paid according to an index that does not accurately reflect their actual labor market conditions.

These problems have led to numerous complaints about inequities in PPS payments. Hospitals in many rural areas have argued that they are treated unfairly because they compete for labor with hospitals in nearby MSAs. Similarly, hospitals in the highly urbanized central counties of MSAs have argued that their payments are too low because they are grouped with suburban hospitals.

In OBRA 1989, Congress established the Medicare Geographic Classification Review Board to consider hospital applications for geographic reclassification. Under this legislation, hospitals are permitted to apply for reclassification for the purpose of the wage index, the standardized amount, or both. Generally, hospitals may apply for reclassification to an adjacent MSA, or to an adjacent statewide rural area.

In its first year of operation, more than 1,100 hospitals applied to the board for reclassification effective in fiscal year 1992, mostly for the purpose of the wage index. About 90 percent of all applications were approved by the board. As a result, more than one-quarter of all rural hospitals and about 6 percent of urban hospitals have been reclassified from the PPS labor market areas in which they are actually located to nearby (generally urban) labor market areas.

These reclassifications have led to substantial increases in payments for many hospitals. HCFA estimated that payments to hospitals reclassified for the wage index would increase in fiscal year 1992 by 5.2 percent, due to reclassification alone. The estimated increase averaged 6.8 percent for reclassified rural hospitals and 2.9 percent for reclassified urban hospitals.

Statutory provisions governing the calculation of the wage index after reclassification protect most hospitals from declines in their wage index values. Therefore, the increase in aggregate payments due to reclassification was substantially larger than it otherwise would have been. However, the statute

also requires the Secretary to adjust the standardized payment amounts for urban hospitals so that aggregate PPS payments do not change as a result of reclassification. Consequently, payments to urban hospitals were reduced by 1.0 percent (about \$450 million) in fiscal year 1992. Thus, payments are expected to increase about 2.9 percent for urban hospitals that were reclassified for the wage index. Payments are expected to decline by 1.0 percent for most of the remaining urban hospitals.

ProPAC analysis of the recent reclassification decisions suggests that this policy has failed to resolve many of the problems it was intended to address. Although reclassification has clearly increased payments for many of the affected hospitals, large differences in wage index values still exist across the boundaries of adjacent labor market areas. The current labor market areas also continue to include diverse sets of hospitals with widely varying hourly compensation rates. Further, the reclassification process has created a sizable ongoing administrative burden and considerable uncertainty for hospitals.

Some of the failure of reclassification may be due to problems with the qualifying criteria. Improvements in the criteria for approving reclassification requests could reduce the number of inappropriate reclassifications. However, this would not solve the fundamental problems associated with the current labor market definitions because reclassification modifies only the edges of each labor market area.

Congress has continued to receive numerous complaints about the fairness of the wage index. Consequently, both the Senate Finance Committee and the House Ways and Means Committee have asked ProPAC to develop a new approach to labor market definitions. The American Hospital Association and HCFA have also expressed strong interest in this effort.

The most serious limitations of the current labor market definitions are related to the large size and fixed boundaries of MSAs and statewide rural areas. It is assumed, implicitly, that hospitals located within each area compete for labor, while those located on opposite sides of area boundaries do not. This produces large differences in wage index values for adjacent labor market areas. At the same

time, substantial variations in hourly compensation rates within each area are unrecognized.

To define alternative labor market areas that recognize the local nature of labor competition, the Commission plans to develop hospital-specific labor markets based on the set of hospitals located nearest to each hospital, measured by road miles. These labor market areas will not have fixed geographic boundaries like county borders. Instead, for each hospital, the areas will merely identify other nearby hospitals as the most probable competitors for labor. The implicit assumption is that a hospital's nearest neighbors will provide the best measure of the labor market conditions it faces. Because this approach will produce overlapping labor market areas for nearby hospitals, it is likely to reduce substantially the strong boundary effects among labor market areas in the current wage index.

A number of difficult issues need to be resolved to determine whether this approach would result in appropriate labor market areas. Moreover, the distance data needed for this project are not likely to be available before mid-1992 at the earliest. In addition, the analysis will take several months. Thus, even if the project is highly successful, it is improbable that the resulting wage index could be implemented for fiscal year 1993. The Commission believes, however, that other currently available policy options are not likely to produce significant overall benefits. Therefore, ProPAC recommends that Congress await the outcome of this effort before taking further action.

Potential Major Refinements to the DRGs

The Commission has recently completed a partial evaluation of the impact of alternative proposals for major refinement of the DRGs. The results indicate that these refinements would allow more accurate classification and payment for Medicare cases. Further study would be needed, however, to reach a final judgment regarding the desirability of any of the proposed modifications. Therefore, ProPAC is not recommending adoption of major changes at this time. The Commission is interested in the views of hospitals and other entities as it continues to assess the desirability and impact of these refinements.

The Commission recently conducted a partial evaluation of the impact of alternative proposals for major refinement of the DRG patient classification system. These proposals were developed by the Health Systems Management Group at Yale University and by 3M Health Information Systems for New York State.

The results of ProPAC's analysis indicate that both proposals would permit more accurate classification of Medicare patients under PPS. Consequently, payments to hospitals would more accurately reflect cost differences due to variations in severity of illness and other factors.

Adoption of either proposal also would substantially affect the distribution of PPS payments among hospitals. Under current law, the Secretary is required to adjust payments to hospitals so that any change in the DRGs or the DRG weights would be budget neutral. (That is, the standardized payment amounts would be adjusted so that estimated aggregate payments after the change are equal to those that would have been made without it.) This means that changes in the DRGs leading to higher payments for some hospitals must result in offsetting reductions in payments to other hospitals.

On average, either set of DRG refinements would lead to an increase of about 1 percent in payments per discharge for major teaching hospitals and for disproportionate share hospitals located in large urban areas. Conversely, average payments per discharge would decrease by about 1 percent for small rural hospitals and for sole community hospitals. This would occur because the refined DRGs would better reflect differences in the average severity of illness of the patients treated by various types of hospitals.

However, the distribution of PPS payments would change even more within any hospital category. The percentage change in payments per discharge for individual major teaching hospitals would range from -1.8 percent to 2.6 percent using the Yale DRG refinement. Similarly, the percentage change in payments per discharge for individual rural hospitals would range from -3.0 percent to 3.8 percent. The pattern of change would be quite similar under the New York refinement, although the size of the change would be somewhat smaller in every hospital group.

In addition, uncertainty remains regarding other potential effects of adopting either of these refinements. First, it is not clear how much other payment adjustments, such as the indirect medical education or disproportionate share adjustments, would need to be modified to accommodate changes in patient classification. It is also unclear to what extent large differences in payment rates between patients with different classes of comorbidities and complications would encourage undesirable changes in coding behavior. Moreover, the administrative burden hospitals and intermediaries would face in converting to either system is uncertain.

Resolving these issues will require further evaluation. In addition, the Commission believes that it may be more desirable to consider adopting these refinements as part of a broader package of payment reforms. Other reforms might include major changes in the construction of the PPS wage index, changes in the methods and data used to calculate DRG weights, and changes in the definition and financing of payments for outlier cases. (See Recommendation 6 for a discussion of the wage index.) Consequently, ProPAC is not at this time recommending adoption of either of the proposed DRG refinements. The Commission is interested in the views of hospitals and other entities as it continues to assess the desirability and impact of these proposals.

Recommendation 7: Medicare Transfer Payment Policy

Cases transferred out of a hospital should be paid based on a graduated per diem up to the full DRG payment to recognize the higher daily costs associated with the first few days in a patient stay. In addition, outlier payment policy should be reexamined, particularly with respect to transfer cases received by a hospital. The Commission believes that hospitals are penalized by the current payment for transfers and that further examination of whether hospitals have the appropriate incentive to transfer patients, particularly with respect to recuperative care, is warranted.

Medicare cases transferred out of one hospital and into another are paid a uniform per diem based on the DRG, up to the full DRG amount. The final

hospital in a transfer sequence receives the full DRG payment, although the patient involved may be assigned to a different DRG for each hospitalization.

Over the past few years, ProPAC has conducted an extensive analysis of transfer payment policy. The analysis found that the uniform per diem payment provided to the transferring hospital undercompensated the hospital for the care provided. Payment to cost ratios were substantially below average for cases with short lengths of stay, but were closer to average for cases with typical stays. This is because a uniform per diem payment does not recognize the frequently higher costs associated with stabilization, evaluation, and surgery that generally take place early in a patient's hospital stay.

The analysis found that the receiving hospital was also undercompensated for transfer cases due to a higher incidence of outliers among these patients. A ProPAC technical report outlining the findings from the analysis will be published in April 1992.

The Commission believes that the payment system should not influence the decision to transfer a patient. Rather, the decision should be based solely on appropriate patient care. ProPAC is concerned that the current payment method may inappropriately penalize hospitals that transfer patients to another institution for more complex care or for recuperative care.

A graduated per diem payment could more accurately reflect the higher daily costs associated with the first few days of care by more closely tracking these costs. A graduated per diem payment, to vary by day of stay, would be highest for the first day of care and lowest for the last day. The cumulative per diem payments would not exceed the full DRG payment. The methodology for developing a graduated per diem payment could follow a study conducted by RAND for ProPAC (*How Services and Costs Vary by Day of Stay for Medicare Hospital Stays*). This study examined how cost varied for each day of a patient stay for a number of DRGs. The Commission would be happy to work with the Secretary in developing a graduated per diem payment for transfer cases.

The current payment method also discourages the transfer of cases from one hospital to another for recuperative care, as noted above. A graduated

per diem for all but the final admission in a transfer sequence could reduce the penalty faced by these hospitals. However, the full DRG payment amount for cases requiring recuperative care may be too high. Further, it is uncertain whether a graduated per diem payment would affect hospital behavior in these situations. Nor is it known if behavioral change would be desirable. ProPAC therefore encourages the Secretary to explore the benefits of encouraging these kinds of transfers, as well as what payment policy would be appropriate. Finally, the Commission believes PROs should continue to review transfer cases in order to monitor changes in frequency that are related to any new financial incentives.

The Commission is also concerned that Medicare's outlier payment policy penalizes hospitals that receive numerous transfer cases. ProPAC analysis has shown that a larger than average proportion of transfer cases become outliers and that the losses on these cases are substantially greater than those for the average outlier case. ProPAC strongly urges the Secretary to reexamine outlier payment policy, giving particular attention to transfer cases. The Commission also plans to reexamine outlier payment policy in the near future and is willing to work with the Secretary on the issue.

Recommendation 8: Payment for Hemophilia Blood Clotting Factor

The Commission believes that current PPS payment policies are adequate to prevent significant payment inequities for hospitals that treat Medicare beneficiaries with hemophilia. Therefore, ProPAC does not recommend reinstatement of an add-on payment for the costs of blood clotting factor provided to hemophilia patients. However, should the current situation change, the Commission may reevaluate this issue.

In 1989, the Commission recommended implementation of an add-on payment, for a two-year period, for the costs of providing blood clotting factor to Medicare patients with hemophilia. This payment was needed because the prices of clotting factors had risen dramatically in 1987 and 1988. These increases were due mostly to new manufacturing processes designed to reduce the risk of transmitting the human immunodeficiency

virus (HIV). Congress enacted ProPAC's recommendation in OBRA 1989. The add-on payment was effective for discharges occurring after June 18, 1990, and before December 19, 1991. Congress has asked ProPAC to reevaluate this issue.

Reinstatement of the add-on payment for clotting factor could be justified if there were many beneficiaries who required it, if the costs to administer it were substantial, and if these cases were concentrated in a few hospitals. But in fiscal year 1990, there were fewer than 3,000 discharges of Medicare beneficiaries with hemophilia. Not all required blood clotting factor. These cases were treated in more than 1,300 hospitals. Of the hospitals providing this care, 94 percent treated five or fewer Medicare beneficiaries with hemophilia. So there are relatively few of these cases, and they are widely scattered among many hospitals. Further, even though hemophiliacs are, on average, more costly to treat than other cases within a given DRG, there are insufficient data to indicate that these differences are due to the administration of clotting factor.

Current PPS payment policies adequately compensate hospitals that treat Medicare beneficiaries with hemophilia. Hospitals' billed charges, which are used to recalibrate the DRG weights, include the costs of clotting factors. Therefore, these costs are reflected in higher weights for the DRGs that include these patients. In addition, while payment to cost ratios are lower than average for hemophilia discharges compared with all Medicare discharges, the process of averaging offsets the losses from these cases against the profits from cases with lower average costs. Finally, outlier payment policy is designed to provide additional compensation to hospitals for exceptionally costly cases.

If the current situation changes, and future evidence indicates that the costs of administering clotting factors to patients with hemophilia become significantly burdensome for some hospitals, the Commission will reevaluate this issue.

Recommendation 9: Payment for Epilepsy Cases

The current DRG assignment should be revised to account for the resource requirements of patients with epilepsy receiving intensive neurodiagnostic monitoring.

Epilepsy is a chronic disorder of the brain, characterized by the tendency to have recurrent seizures. Approximately 10 percent of epilepsy patients do not attain an adequate level of seizure control: Their seizure disorders are characterized as intractable. In 1987, concerns over the adequacy of PPS payment for the treatment of intractable epilepsy patients receiving intensive neurodiagnostic monitoring were brought to the Commission's attention.

ProPAC reported preliminary findings on this issue in its March 1988 report to the Secretary. At that time, only three centers were identified as providing specialized care for the treatment of intractable epilepsy. Within the two DRGs to which the majority of these cases were assigned (DRG 24 and DRG 25), payment shortfalls were larger for patients with epilepsy than for other patients. However, the Commission deferred making a recommendation at that time because there were no specific codes to identify patients with intractable epilepsy. Since then, the number of hospitals providing these specialized services has increased to more than 40, and codes that distinguish patients with intractable epilepsy have been implemented.

Commission analyses of data from fiscal year 1990 found that the majority of patients with epilepsy are not concentrated in any hospital type. However, hospitals providing specialized services had a higher percentage of patients with epilepsy who receive monitoring. Further, nearly 64 percent of the patients in these hospitals who were assigned to DRGs 24 and 25 had intractable epilepsy, compared with about 31 percent in other PPS hospitals.

Payment to cost ratios were lower for patients with epilepsy compared with other patients in the same DRG. For example, ratios were about 10 percent lower for epilepsy patients compared with other patients in DRG 25. These differences were larger for patients with intractable epilepsy and for those receiving monitoring. In DRG 25, the payment to cost ratios were 18 percent lower for patients with intractable epilepsy. Those receiving monitoring had ratios nearly 22 percent lower than other patients in the same DRG. The same pattern was seen in DRG 24 as well.

Therefore, the Commission believes that the Secretary should evaluate the current DRG

assignment for patients with intractable epilepsy, particularly those receiving intensive neurodiagnostic monitoring. The payment system should not discourage hospitals from treating these patients. The Commission realizes, however, that more accurate codes may need to be implemented to ensure that the appropriate type of monitoring is reflected in the patient records.

Recommendation 10: Essential Access Community Hospital Program

The Commission recommends that the Secretary waive, on an individual case basis, some of the requirements for participation in the Essential Access Community Hospital Program. This would encourage increased hospital participation and allow the Secretary to gain additional experience with alternative policies. Over time, policies should be expanded to target the larger group of hospitals that should continue to operate but offer limited, less specialized inpatient services. By refocusing these hospitals' operations, the Commission believes that overall system efficiency may be improved without sacrificing access to care.

OBRA 1989 required the Secretary of Health and Human Services to establish an Essential Access Community Hospital Program in up to seven states. By restructuring the delivery of services in rural areas, the program seeks to ensure access to care through the provision of emergency services and an entry point for inpatient care. Restructuring is also designed to reduce the cost of providing appropriate care, primarily through downsizing inpatient capacity.

The program requires every participating state to develop a rural regionalization plan with two levels of care. Rural primary care hospitals are to provide emergency and temporary inpatient care for cases needing stabilization prior to discharge or transfer. Essential access community hospitals are to act as full-service referral hospitals for the RPCHs.

Participating RPCHs must transform from providing routine inpatient care to offering more limited emergency inpatient and outpatient services.

Specifically, all hospitalizations in RPCHs must be certified as emergencies by a physician, and patients must be discharged or transferred within three days. In addition, a RPCH is limited to six inpatient beds, unless the hospital has swing beds. In that case, the RPCH may have up to 12 total beds, with no more than 10 beds concurrently used for skilled nursing level services. Further, formal agreements with at least one other hospital must be established for the referral and admission of cases that cannot be treated at the RPCHs. By limiting the services offered at these hospitals, the extra costs of maintaining inpatient capacity while serving a small number of patients may be avoided. Instead, local residents requiring non-emergency inpatient care are to be treated in a hospital offering an appropriate array of services.

The Commission agrees with the intent of this program. Nevertheless, it has concerns regarding several specific RPCH provisions, as outlined in its report to Congress, *Rural Hospitals Under Medicare's Prospective Payment System*. ProPAC questioned the following: (1) the condition of payment requiring certification that the admissions were required on a temporary, inpatient basis; (2) the six-bed limitation; and (3) the maximum three-day length of stay.

The program also contains several provisions for EACHs. These facilities must be located 35 miles from another EACH or rural referral center and have at least 75 beds. The hospitals must agree to provide emergency and medical backup services to RPCHs, offer admitting privileges to RPCH physicians, and accept RPCH patients as transfers. The Commission is troubled by the 75-bed requirement, which may encourage unnecessary bed capacity or disallow participation of small, full-service hospitals.

In the Commission's judgment, the EACH program provisions are so restrictive that many otherwise eligible hospitals may choose not to participate. Without sufficient participation, the program is unlikely to meet its goals. Therefore, ProPAC encourages the Secretary to waive certain provisions on an individual case basis. This flexibility may result in higher hospital participation while experience is gained regarding alternative policies.

The EACH program is not designed to solve the problems facing those rural hospitals that wish to remain open but are not financially viable in their current configuration. Because this program is limited to hospitals that will discontinue their routine inpatient care, it is unlikely to have a large impact on the organization and delivery of rural hospital care. Thus, the Commission recommends that policies eventually should be expanded to target larger hospitals that will remain open as inpatient facilities. These hospitals should be made more efficient through appropriate restructuring of their services. The Rural Transition Grant Program, administered by HCFA, is one effort aimed at helping hospitals adapt to their changing circumstances. Begun in 1987, this program provides funds to help small rural not-for-profit hospitals and their communities adapt to changing demand for services, excess acute care capacity, and the inability to provide appropriate staffing. It is designed to ensure access to emergency and inpatient care in areas where services are eliminated.

Alternatively, the EACH program could be expanded to permit the participation of hospitals offering routine inpatient services for treatment of appropriate cases. This could enable other hospitals that wish to remain open to use EACH funds to downsize and develop linkages with full-service hospitals. The Commission would gladly collaborate with Congress and other interested parties to develop a workable strategy to achieve a more efficient hospital system.

PRO Review and Quality of Care

The Commission believes the Peer Review Organization program should continue to monitor, at the case and facility levels, the care furnished to Medicare beneficiaries. Although the Commission commends the planned expansion of epidemiologic patterns of care studies using the Uniform Clinical Data Set, these more general analyses should not replace all case-level and facility-level quality review. Further, funding should be sufficient to allow PROs to perform case-level and facility-level review, as well as more general analyses of broad patterns of care.

Peer Review Organizations, which are private organizations under contract to HCFA, generally

operate at the state level. These organizations review hospital medical records in a given state to determine whether payment should be made for services provided under Medicare. HCFA specifies the major responsibilities of the PROs in their contracts, which are awarded for three years. One-third of these contracts come up for renewal each year.

Historically, the mandate of the PROs has included quality of care and utilization review at the hospital level. Past ProPAC recommendations have addressed the need to improve quality of care review by, for instance, implementing better quality screens (the specific criteria against which care is evaluated). The Commission has also called for more sophisticated methods of quality review that emphasize outcomes measures.

The fourth PRO contracting cycle began in the fall of 1991. The contracts issued during the latest cycle reflect the Secretary's overall strategy of shifting the PRO program's focus from an emphasis on individual record review to a more systematic analysis of patterns of use and patterns of outcome. This strategy is consistent with recommendations made in the recent Institute of Medicine (IOM) report, *Medicare: A Strategy for Quality Assurance*. The IOM's recommendations reflect its belief that hospitals, together with their medical staffs, will continue to improve the quality of care furnished to all patients.

In conjunction with this changed focus, the Uniform Clinical Data Set (UCDS) is being implemented. An automated record review system, the UCDS is designed to standardize the review process and produce a detailed, patient-level database. This database will be important in conducting epidemiologic studies of patterns of health care delivery. The Commission strongly supports this type of activity.

However, with increased emphasis on a more nationally representative database, the hospital-level review of the care furnished to Medicare beneficiaries has been deemphasized. No other external entity will perform this function. The Commission is concerned that this shift in PRO orientation is at the expense of quality monitoring at the individual and facility level. All levels of quality should be examined, from individual cases and facilities to local, regional, and national patterns of

care. Therefore, although the UCDS is a useful and important tool, it does not substitute for facility and case-level review of the quality of care provided to Medicare beneficiaries.

PRO funding should be sufficient to provide for adequate review at the case and facility level. Funding should also permit analyses of broad patterns of care. ProPAC is concerned that budget cuts will have an unfavorable impact on both of these important types of activities.

Updating and Adjusting Payments to PPS-Excluded Hospitals and Distinct-Part Units

Since the implementation of Medicare's prospective payment system in 1983, certain hospitals (psychiatric, rehabilitation, long-term, and children's) and distinct-part units (psychiatric and rehabilitation) have been exempt. Further, cancer hospitals were exempted from PPS as a result of OBRA 1989. The primary reason for their exemption was that DRGs failed to predict accurately the resource costs for patients treated by these providers.

PPS-excluded hospitals and distinct-part units are subject to the payment limitations and incentives established in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). They are paid on the basis of each facility's historical costs trended forward, with a limit placed on the rate of increase in per case reimbursable costs. These TEFRA target rate-of-increase limits are updated annually. The target rate per discharge is based on hospital-specific Medicare costs in a base year, which varies depending on when the facility was constructed or converted to a PPS-excluded category.

Facilities with costs less than the target rate per discharge receive their costs plus an additional payment that is the lesser of 50 percent of the difference between their costs and the TEFRA target rate, or 5 percent of this target rate. Beginning in fiscal year 1992, providers with costs exceeding their target rates will receive 50 percent of these costs subject to a total payment ceiling of 110 percent of the target amount. Further, the Secretary is required to provide for an adjustment to the amount of payment for a hospital when events beyond the hospital's control distort the increase in costs for a cost reporting period.

The TEFRA target rate-of-increase limits are updated annually. PPS-excluded hospitals and distinct-part units received the same update provided to PPS hospitals until fiscal year 1989. Congress then set the TEFRA target rate update equal to the projected increase in the market basket. Beginning in fiscal year 1991, the Secretary has implemented a separate market basket for PPS-excluded providers. Although the update has been legislated, Congress requires the Commission and the Secretary of HHS to recommend an annual update factor to the TEFRA target rates.

OBRA 1990 requires the Secretary to develop a proposal to modify the current payment system for PPS-excluded providers (including operating and capital-related costs) or to replace it with a prospective payment system. The Secretary is required to submit this report by April 1, 1992. ProPAC is to analyze and comment on the Secretary's proposals by June 1, 1992.

Recommendation 11: Fiscal Year 1993 Update Factor for PPS-Excluded Hospitals and Distinct-Part Units

For fiscal year 1993, the target rate of increase for PPS-excluded hospitals and distinct-part units should be updated to account for the following factors:

- **The projected increase in the HCFA PPS-excluded hospital market basket, currently estimated at 4.6 percentage points;**
- **An upward adjustment of 0.2 percentage points, to reflect the difference between HCFA's market basket and that recommended by ProPAC;**
- **A correction for fiscal year 1991 market basket forecast error of -0.7 percentage points; and**
- **An allowance for scientific and technological advancement of 0.1 percentage points.**

In addition, a positive allowance should be given to TEFRA providers that entered the program before fiscal year 1989, depending on the year on which their target rates were

based. This allowance should reflect the difference between the actual updates given to their target rates in earlier years and the market basket for those years. It should result in aggregate payments that are budget neutral with respect to the legislated update.

The legislated update to the TEFRA target rate equals the projected increase in the market basket. The Commission's recommendation results in an average update to the target rate equal to the market basket minus 0.4 percentage points (see Table 2-3). The savings achieved from this reduction should be used to fund the allowance for the pre-1989 TEFRA providers.

Market Basket—The update recommendation is determined primarily by the projected increase in the PPS-excluded market basket index. The current HCFA market basket forecast for fiscal year 1993 is 4.6 percent. The Commission, however, believes that the market basket as currently constructed does not adequately recognize the unique characteristics of the hospital labor market. The major reason is that the proportion of internal hospital wages used in the wage component of the HCFA market basket is understated. (See the discussion of the market basket index in Appendix A.) Therefore, the Commission recommends an additional 0.2 percentage point adjustment.

Forecast Error Correction—ProPAC continues to believe that the update should be corrected for past market basket forecast errors. This requires comparing the actual market basket increase in a given year with the forecast used to update payments in that year. A two-year lag exists between when the forecast is used and when the actual market basket increase is known. In the Commission's judgment, corrections should be made only for errors that equal or exceed 0.25 percentage points. Taking this approach, the Commission compared the actual fiscal year 1991 market basket increase with the forecast used to update the TEFRA target limits in that year. The fiscal year 1991 market basket forecast was 5.3 percent, and the actual market basket increase was 4.6 percent. The forecast error correction for fiscal year 1991 is thus -0.7 percentage points.

Scientific and Technological Advancement—ProPAC has also developed an allowance for scientific and technological advancement for PPS-excluded facilities. This allowance reflects the Commission's judgment about hospitals' financial requirements for the adoption of quality-enhancing but cost-increasing technologies. To arrive at an informed judgment on the allowance, each year ProPAC examines a set of the most important new technologies and scientific advances used in PPS-excluded facilities. Based

Table 2-3. Recommended PPS-Excluded Update Factor for Fiscal Year 1993

Components of the Update

Components applied to all hospitals and distinct-part units:

Fiscal year 1993 HCFA PPS-excluded market basket forecast ^a	4.6%
Adjustment for difference between HCFA and ProPAC market baskets ^a	0.2
Correction for fiscal year 1991 forecast error	-0.7
Allowance for scientific and technological advancement	0.1

Average update before positive allowance adjustment

4.2

Basis for cumulative positive allowance adjustment^b

1984-1988	2.1
1985-1988	4.2
1986-1988	6.9
1987-1988	4.4
1988	2.1

^a Market basket forecast provided by the Health Care Financing Administration, Office of the Actuary, December 1991. The market basket forecast is subject to change as more current forecasts become available.

^b Federal Register 56(106), June 3, 1991, 251778-25323.

on this examination, an increase of 0.1 percentage points to the target rate is needed to offset the cost of new technologies.

Unlike the update for PPS hospitals, the update for excluded facilities should not include a productivity adjustment. The productivity adjustment to the PPS update is based on the principle that Medicare should share in the savings generated by productivity improvements. However, Medicare automatically shares in the savings under TEFRA. Facilities with costs less than the target amount receive their costs plus the lesser of 5 percent of the target amount, or 50 percent of the difference between their target amount and costs. Therefore, part of any productivity increase is factored into reduced Medicare payments. ProPAC believes that further reductions in payments for productivity improvement are not appropriate for PPS-excluded providers.

Positive Allowance—Based on the Commission's initial analysis of PPS-excluded facilities, it appears that the earlier a provider was excluded from PPS, the more financially vulnerable it has become. This is partly because hospitals and distinct-part units excluded before fiscal year 1989 received the same update as PPS hospitals. The PPS update was reduced to account for growth in payments resulting from CMI increases. PPS-excluded providers, however, did not benefit from increased payments due to CMI changes.

ProPAC believes that these providers should have received the full increase in the market basket during this period. To ensure budget neutrality, the savings achieved from the Commission's average update recommendation should be distributed to these providers based on the difference between the market basket increase and the actual update received. Further, the Secretary is required to provide for adjustment of a hospital's payments when events beyond its control affect the increase in costs during a reporting period. In general, the provider must request an adjustment each year in which costs exceed payments. In these cases, the Secretary is permitted to use the most appropriate method for adjustment, including the assignment of a new base year.

ProPAC believes that giving a positive allowance to providers excluded in the early years will reduce the amount of the adjustments that will

be requested and granted in the future. The savings based on the difference between the market basket increase and the actual update should be considered in determining the positive allowance. Again, providers that had new target rates computed to reflect more recent cost data should not receive the positive allowance.

The Commission will continue to evaluate the appropriateness of the TEFRA system for PPS-excluded providers. As required by Congress, ProPAC will prepare a report by June 1, 1992, analyzing and commenting on proposals developed by the Secretary. If the Secretary's report is delayed, the Commission will submit a preliminary report in June 1992 evaluating TEFRA payment policy. Several factors will be examined, including (1) cost and payment increases in PPS-excluded facilities, (2) payment variation and potential reasons for it, and (3) beneficiaries' access to services at these facilities. Further, the report will review the general criteria for reform and present various payment policy options. The Commission will submit a subsequent report reviewing the Secretary's recommendations, as appropriate.

Finally, ProPAC believes that the Secretary should systematically collect data on successful adjustment applications. Medicare Cost Report data are a valuable source of information used to assess the financial effects of TEFRA. However, cost reports are not amended to reflect these adjustments. Therefore, these data may not accurately reflect the overall impact of TEFRA payments on providers.

Updating Payments to Dialysis Facilities

The Omnibus Budget Reconciliation Act of 1990 directs the Commission to recommend "an appropriate change factor which should be used for updating payments" for the facility component of dialysis services. This recommendation is due by March 1 of each year, starting in March 1992 for services provided in fiscal year 1993.

The legislation also instructs the Commission to submit a report in June 1992 that includes recommendations regarding payment methods and levels for the facility component of dialysis services. In making these recommendations, ProPAC is to study the costs, services, and profits associated with the various types of dialysis.

Since 1983, dialysis facilities have been paid a prospectively set amount per dialysis treatment; hospital-based facilities and independent facilities receive slightly different base rates. The rate was set using a sample of Medicare Cost Reports from 1977 through 1979. This prospectively set rate is referred to as the composite rate, because it was based on a formula that factored in the lower costs of providing dialysis at home and the proportion of patients receiving dialysis in this setting. While this payment rate was meant to encourage the use of home dialysis, the proportion of patients receiving such treatment has increased only minimally. This increase is due to growth in the number of patients receiving peritoneal dialysis at home. The number of home dialysis patients receiving hemodialysis has decreased since 1983.

Although there have been some minor changes to base payment rates, they are essentially the same as the rates set in 1983. There has been no annual process for updating payment to dialysis facilities like the one used in PPS.

Recommendation 12: Update Factor for Payments to Dialysis Facilities

The Commission is not recommending an increase in payments for dialysis services at this time. Currently, data are inadequate to assess the relationship between the payments and the costs of furnishing various types of dialysis services in different settings. The Commission recommends that HCFA expedite work necessary to complete its database of unaudited dialysis facility cost reports. In addition, HCFA should annually audit the cost reports of a representative sample of dialysis facilities and maintain a database with this information.

The Commission believes that developing an appropriate update factor for dialysis services requires information on payments and costs for the different types of dialysis furnished in the alternative settings. Existing data are inadequate to evaluate payments and costs by type of treatment and by setting.

The latest available data are from a sample of 1988 audited cost reports, which was to be the

basis for proposing new payment rates. The sampling strategy was intended to produce cost estimates that reflected efficiently produced services. To do this, larger facilities with lower production costs were overrepresented. This sampling strategy was appropriate for its originally intended purpose. But because it was not representative of all dialysis facilities, the sample did not allow the comprehensive evaluation of costs and payments that the Commission believes is necessary.

Patients may receive hemodialysis or peritoneal dialysis. These services may be provided by hospital-based or independent facilities in the facility or in the home. The 1988 audited cost report sample was not representative of either the proportion of patients treated at home or the types of dialysis provided. Nor did it represent other facility characteristics that should be analyzed, such as location, size, chain affiliation, ownership, and whether the facilities were hospital-based or independent. To correct these data deficiencies, the Commission recommends that HCFA expedite the collection of unaudited cost report data from later years and complete the work necessary to make this database operational. In addition, HCFA annually should audit a representative sample of cost reports to use in evaluating payments and costs by type of treatment and setting.

The sampling issues inherent in the available cost report data create problems for many analyses. These data, however, represent the best systematically collected information available on costs per treatment in hospital-based and independent facilities, and therefore on the industry's financial status. In 1988, the costs of hospital-based facilities were, on average, higher than Medicare payments, whereas costs in independent facilities, the largest group, were lower. The majority of facilities were profitable in 1988. Other organizations that did similar analyses using data from 1988 or before reached comparable conclusions.

Additional analyses, notably one conducted by the Institute of Medicine (IOM) entitled *Kidney Failure and the Federal Government*, indicate that facilities have apparently been able to adapt to unchanged payment rates by introducing productivity improvements. These improvements are based at least partly on scientific and technological advances that have reduced the time needed to

dialyze patients and, hence, the labor and other costs associated with each dialysis session. Another productivity improvement occurring during the 1980s was the increased reuse of dialyzers, a key component in the dialysis process. The IOM report states that "the introduction of the composite rate in 1983 had several general effects on providers and, derivatively, on innovation. It increased the severity of the economic discipline on all providers, further encouraging the search for efficiency."

Evidence concerning quality of care is inconclusive. Further, even though payments have not changed since 1983, the number of dialysis facilities continued to grow steadily through 1989, suggesting that access to care has not been reduced.

On the basis of this information, the Commission believes it is appropriate to wait until data are available to evaluate the dialysis industry thoroughly before recommending an update factor. In its June report on dialysis payment rate, ProPAC will describe its approach to a comprehensive analysis of the dialysis facilities and the issues related to developing an update to payment rates.

Improving Hospital Outpatient Payment Policy

During the 1980s, there was unprecedented growth in the delivery of care in the outpatient setting. Medicare payments for outpatient hospital services increased more than three times faster than those for inpatient services between 1984 and 1990. Outpatient revenues are a particularly large proportion of total revenues for small hospitals and for those located in rural areas.

OBRA 1990 requires the Commission to issue a report by March 1, 1992, analyzing and commenting on the Secretary's proposal for developing a hospital outpatient payment based on prospectively determined rates. Although the Secretary has not yet issued a report, ProPAC will present its recommendations to Congress by the mandated date. The Commission will comment on the Secretary's proposal after it is released.

The following nine recommendations are excerpted from ProPAC's report. They provide principles for improving the outpatient payment system, and apply these principles to specific recommendations on ambulatory surgery and outpatient radiology services.

Recommendation 13: Outpatient Payment Reform

The Commission believes that a prospective payment system for outpatient services should be implemented. Outpatient facility payment reform should ultimately include all providers of outpatient services, such as hospitals, physicians' offices, and free-standing ambulatory surgical centers.

The same payment method should apply to the facility or technical component of all services. The payment rate, however, should be adjusted to reflect justifiable cost differences such as wages and case mix. Further, cost differences that have some societal benefit like, for example, standby capacity and emergency capabilities, should also be reflected in the payment rate. Where feasible, the unit of payment should be based on bundled related services.

The Commission believes that one major goal of outpatient payment reform is to provide incentives for controlling total expenditures in an appropriate manner. Reform should reward providers for delivering cost-effective quality care in the appropriate setting. A prospective payment method promotes incentives to deliver cost-effective care by allowing an opportunity for a profit as well as the risk of financial loss. However, ProPAC realizes that various payment methods may be used during the transition to a fully prospective system.

In attempting to control total costs, the Commission recommends that outpatient reform should eventually include all providers of ambulatory care, including physicians' offices and independent laboratories. This broad scope is necessary because most ambulatory care is furnished outside of the hospital setting.

Physicians and beneficiaries should not have financial incentives to favor one site of care over another, but should choose the most medically appropriate site. Applying the same prospective payment method to all outpatient services, regardless of whether care is provided in hospitals, free-standing ambulatory care settings, or physicians' offices, will help achieve this goal. Using the same method of payment, although not necessarily the same level of payments, will help ensure that payment incentives across providers are consistent.

Although the reforms should be applied to all providers of outpatient services, the payment rate may vary for different providers. There are many reasons why costs may differ among similar providers (such as teaching and non-teaching hospitals) and across treatment sites (such as hospitals and physicians' offices). These factors include differences in patient severity, the intensity of teaching activities, and geographic location. The Commission believes it is desirable to adjust for some of these factors in the payment system, particularly those that represent a benefit to society and are beyond the control of the provider. (See Recommendation 21.) However, the lack of cost data for free-standing settings may complicate the determination of appropriate differences in payment rates. (See Recommendation 15.)

ProPAC recommends that outpatient facility payment reform should contain incentives consistent with those of physician payment reform. Beginning in 1992, physicians will be paid using a resource-based Medicare Fee Schedule. The fee schedule is designed to increase payment equity among physicians, constrain Medicare expenditures, protect beneficiaries' access to services, and promote predictability and administrative simplicity. The Commission believes that these features should also characterize the reform of outpatient payment methods, as it noted in its March 1991 *Report and Recommendations to the Congress*.

While a prospective payment method controls the price of the individual unit of service, it has limited impact on the volume of services provided. (See Recommendation 14.) ProPAC believes that over time, payment should move from the current fee for an individual service to a larger payment unit containing more services (known as bundling).

A bundling approach is necessary to control the volume and intensity of services provided. These packages, or bundles, could be based on services furnished during a single visit or over multiple visits, such as a week or an entire episode of care. Eventually, payments could be set to cover the costs of bundles of services deemed to be appropriate or necessary for high-quality, cost-effective care.

Initially, there may be less comprehensive approaches to bundling. Analysis of the 1987 hospital outpatient file by the Urban Institute, for example, indicates that bills for certain outpatient services had a significant number of related ancillary charges (such as radiology and laboratory). Nearly 58 percent of surgical claims had ancillary charges. This suggests that limited bundling for selected services in the hospital outpatient setting may be appropriate.

To define the unit of payment, the Commission supports the research funded by the Secretary to develop a classification system for ambulatory services. However, ProPAC is concerned that this research currently focuses only on hospital-provided outpatient services. For example, the Ambulatory Patient Groups (APGs) outpatient case-mix classification system was developed for use in the hospital outpatient setting. While additional research is under way, it is unclear whether APGs can be appropriately applied in the non-hospital setting.

To the extent that free-standing facilities are providing the same package of services, ProPAC believes any classification system should be applicable to these settings as well. The Commission encourages the expansion of the Secretary's research in this direction.

Recommendation 14: Medicare Volume Performance Standard

Services provided in the hospital outpatient setting should be included in the Medicare Volume Performance Standard (VPS) to the extent that these services are included when provided in other settings. Certain services, such as laboratory tests and therapy, currently are included in the VPS when they

are furnished in free-standing settings. The Commission believes that hospital-provided services should also be incorporated in the VPS. Their inclusion will make incentives to control volume consistent across sites of care.

Several of Medicare's current outpatient payment methods (such as blended rates and fee schedules) control the price of individual services. However, these payment methods fail to control the volume of services provided. The Commission believes that a policy to control inappropriate volume is warranted.

The Volume Performance Standard, enacted in OBRA 1989, offers an approach for controlling some Medicare Part B expenditures. The primary purpose of the VPS is to provide a collective incentive for physicians to control the rate of increase in the volume and intensity of services furnished to beneficiaries. The VPS is designed to give physicians incentives to order fewer tests and other procedures of limited value to patients. The Commission realizes that reductions in volume and intensity growth will be achieved gradually.

Services commonly furnished by physicians or in physicians' offices and billed through Part B carriers are included in the VPS. Services provided in the hospital outpatient setting and billed through Part A fiscal intermediaries are excluded because the intermediaries do not collect service-specific data. To the extent that these services are included in the VPS when provided in free-standing settings, they should also be included when supplied by hospitals. This change would prevent physicians from attempting to circumvent the objectives of the current VPS. Since hospital-provided outpatient laboratory services are not included in the VPS, for example, physicians have incentives to shift these services to the hospital setting. If these services were included in the VPS, physicians would have the same incentive to control their use as they would to control the use of laboratory tests performed in their offices or independent laboratories.

In his response to the Commission's previous recommendation, the Secretary has stated that outpatient hospital services may be included in the VPS as data systems evolve over time. ProPAC believes that the Secretary should

advance the development of these systems so that outpatient services provided in the hospital setting can be included in the VPS as soon as possible.

Recommendation 15: Cost Data Collection for Outpatient Providers

A mechanism for periodic collection of procedure-specific cost data in free-standing settings, including physicians' offices and ambulatory surgical centers, should be implemented.

To implement and maintain a prospective payment system across outpatient providers, comparable patient and financial data are needed. Under a prospective payment rate, comparisons must be made between hospitals and other providers of ambulatory care—such as physicians' offices and free-standing ambulatory surgical centers (ASCs)—to determine the appropriate level of payment.

Cost data for free-standing settings therefore are necessary to ensure comparable financial incentives across different types of providers. However, data are not now available to compare the costs of ambulatory care across providers. Because most outpatient services are available in a variety of settings, the Commission believes that collection of non-hospital cost data is necessary to develop appropriate outpatient payment policy.

ProPAC believes that systematic and comprehensive methods of collecting data on services provided in non-hospital settings need to be developed. For ambulatory surgical centers and some other types of providers, an annual cost report would be the appropriate data collection mechanism. The Secretary's survey of ASCs could serve as a model for collecting service-specific cost data from other ambulatory care providers. The Commission supports the research being conducted by the Physician Payment Review Commission (PPRC) on the direct practice costs for certain services provided in physicians' offices. This research will provide guidance on how service-specific cost data can be collected in these settings.

In the short term, alternative methods for using readily available data should be considered. Data used to construct the practice expense component

of the fee schedule, for instance, may be useful in establishing a fair price for services across settings. The Secretary has indicated that alternative methods for data collection will be explored. The Commission intends to work with both the Secretary and PPRC in assessing available data sources.

Recommendation 16: Beneficiary Liability

Beneficiary Part B coinsurance for hospital outpatient services that are paid for prospectively should be limited to 20 percent of the payment amount allowed by Medicare.

Under current law, beneficiary liability for outpatient services differs depending on the site of care. In the hospital outpatient setting, for example, coinsurance equals 20 percent of submitted charges. In free-standing ambulatory surgical centers, however, coinsurance equals 20 percent of the ASC payment rate. The ASC payment rate is likely to be lower than charges submitted by hospitals.

Historically, hospital outpatient services were reimbursed on the basis of reasonable costs. These costs could not be determined until after the services were performed. Consequently, it was administratively infeasible to base beneficiary coinsurance on actual Medicare payments or costs. As a result, beneficiary coinsurance was based on submitted charges, which were known when the services were performed. Some hospital services are still reimbursed on the basis of reasonable costs. However, when services are paid prospectively, as recommended in this report, Medicare reimbursement will be known at the time services are furnished. Therefore, it will be feasible to follow Medicare's general policy—that beneficiary coinsurance equal 20 percent of the payment amount and Medicare payment, 80 percent.

Analysis conducted by the Commission indicates that beneficiary coinsurance tends to be higher in hospital settings than in free-standing settings. For example, for hospital-provided ASC-approved surgery and radiology services, patients may pay as much as 35 percent and 46 percent, respectively, of the amount Medicare ultimately allows.

In the Commission's view, this policy unfairly penalizes beneficiaries who receive care in the

hospital outpatient setting. ProPAC believes legislation should be adopted to eliminate this discriminatory policy and reduce the burden on beneficiaries who use hospital outpatient services.

The Commission realizes that this policy will increase Medicare expenditures. However, the Medicare program should assume responsibility for 80 percent of the payment amount. If such an increase in expenditures is unacceptable, less discriminatory ways of sharing the financial burden should be explored.

Recommendation 17: Quality of Care in Outpatient Settings

The Commission is concerned about the lack of Federal quality oversight in many ambulatory care settings. As more services are furnished in outpatient settings, ProPAC believes the Secretary should enhance existing methods and develop new ones to assess and monitor the quality of care provided to beneficiaries in these settings.

The quality of care provided in hospital outpatient departments and free-standing ambulatory surgical centers is subject to some Federal review, primarily through Medicare conditions of participation and PRO activities. Many other ambulatory care settings, however, are not subject to any Federal quality assurance mechanisms. Medicare conditions of participation require a setting to be inspected by the Medicare program, or some agent of the program, to ensure that it meets specific quality standards. Peer Review Organizations have medical practitioners review cases of beneficiaries seen in specific settings to make certain these standards have been met.

By contrast, many ambulatory care settings, including ambulatory care centers, diagnostic imaging centers, cancer centers, and lithotripsy centers, do not have to meet any Medicare conditions of participation, nor are they subject to PRO review. Some of these facilities are voluntarily accredited by private organizations, although many do not even undergo voluntary accreditation. In addition, many surgical procedures previously performed in hospitals now can be performed in

physicians' offices, for which there is no Federal oversight of quality assurance mechanisms.

PROs review a sample of cases treated in hospital outpatient departments and in ASCs. However, the sample of ambulatory surgery cases reviewed in these facilities has recently been reduced from 5 percent to 3 percent. Cases treated in hospital outpatient departments are reviewed only if the outpatient services were received between hospitalizations that occurred within 31 days of each other. Because these "intervening care" cases are part of a random 10 percent sample of beneficiaries who were discharged from a hospital, the number of a hospital's outpatient cases the PRO reviews can be quite small.

As more care is delivered in ambulatory settings, the Commission is concerned about the limited role of the PROs and the lack of any Federal quality oversight for much of this care. In addition, many of the voluntary accreditation processes do not focus on outcomes of care, but rather on the physical aspects of the settings and the procedures used to provide care. The Commission believes that more emphasis should be placed on ensuring the quality of ambulatory care and, more specifically, evaluating quality in terms of the outcomes.

Recommendation 18: Payment for Hospital-Provided Outpatient ASC-Approved Surgery

The Commission believes that payments for ambulatory surgery performed in the hospital outpatient setting should be fully prospective based on national rates adjusted for area wage differences. The payment rates should be established using average hospital costs and free-standing ASC payments. These rates should be computed in a budget neutral fashion; that is, aggregate spending should neither increase nor decrease. National rates should be based on the classification system used to determine payments to free-standing ASCs. However, the Commission believes this classification system should be revised. The rates should be updated annually using an appropriate update factor.

The Commission supports congressional intent to establish prospective payment methods for

outpatient services. These methods will create incentives for controlling total expenditures by encouraging hospitals to deliver cost-effective care. Thus, providers will have the opportunity for a profit as well as the risk of financial loss. In addition, prospective payments are more predictable.

The current payment method for ambulatory surgery fails to achieve this goal. Hospitals are paid the lesser of costs (or charges, for those hospitals with charges below costs) or a blended amount, which is equal to 42 percent of hospital-specific costs and 58 percent of the ASC payment rate. This method provides no incentive for hospitals to lower their costs. If a hospital reduces its costs, the payments it receives correspondingly decline, thus eliminating some of the incentive to deliver care more efficiently. By contrast, ASCs are reimbursed on the basis of a prospective fee schedule for the same service, thereby providing more incentive to control costs.

The Commission believes that payment rates should recognize justifiable differences in the costs of furnishing services. Costs may differ between hospitals and free-standing providers for several reasons, including patient severity, stand-by capacity, and the presence of an emergency room. While there are no data to measure the costs in free-standing settings, payment rates between these settings and hospitals vary. Lacking complete information on the reasons for these payment differences, ProPAC believes that hospitals' rates should incorporate a portion of the difference between hospital costs and the ASC payment rates.

The Commission realizes that if national rates were established in this manner, without modification, Medicare expenditures would increase. For example, preliminary analysis indicates that about 26 percent of hospitals currently receive payments for all ambulatory surgery based on costs or charges. This indicates that the costs or charges of these hospitals are below the comparable ASC payments. Paying these hospitals the current blended rate will increase Medicare expenditures. Therefore, the Secretary should adjust the national rates to maintain budget neutrality. ProPAC's preliminary estimates indicate that the national rate will reflect a 28:72 blend of average hospital costs and the free-standing ASC rate. These rates should be

updated annually to reflect increases in the market basket and other appropriate cost increases.

ProPAC believes that better cost data are necessary to understand the implications of using current ASC payment rates. (See Recommendation 15.) Such data will help to determine the reasons for and the magnitude of cost differences between settings. Future payment rates could be adjusted to reflect better cost data. In addition, these national rates should be adjusted to reflect differences in wages. (See Recommendation 21.) Finally, the classification system used to group cases for payment should include both ASC and hospital cases. (See Recommendation 19.)

Recommendation 19: Revision of the Classification System Used to Group Ambulatory Surgery Cases

The Secretary should revise the classification system used to group ambulatory surgery cases for payment. Cases treated in both hospitals and free-standing ambulatory surgical centers should be used to establish the payment groups.

The current classification system used to group cases for ambulatory surgery payment was developed using cases treated in free-standing ASCs. Audited charge data for 90 ASCs were standardized for area wage differences, converted to costs using an average cost to charge ratio, and arrayed in descending order. The procedures were then classified into the payment groups using \$75 intervals. Over time, as the number of approved ASC procedures has increased, the number of surgery groups has increased from four to nine.

The Commission is concerned that the current ASC classification system may not accurately reflect the costs or mix of cases treated in hospitals. It is likely that the mix and costs of hospital cases would result in different groupings. Thus, while the number of groups may remain the same, the classification of certain procedures may vary from the current classification system. Therefore, the Commission recommends that hospital data be combined with free-standing ASC data in establishing the classification system used for payments.

Recommendation 20: Payment for Hospital-Provided Outpatient Radiology Services

The Commission believes that payments for radiology services provided in the hospital outpatient setting should be fully prospective based on national rates adjusted for area wage differences. The payment rates should be established using average hospital costs and the technical component of the Medicare Fee Schedule for physicians. These rates should be computed in a budget neutral fashion; that is, aggregate spending should neither increase nor decrease. The national rates should be updated annually using an appropriate update factor.

The Commission supports congressional intent to establish prospective payment methods for outpatient services. These methods will create incentives for controlling total expenditures by presenting the opportunity for a profit as well as the risk of financial loss. Thus hospitals will be encouraged to deliver cost-effective care. In addition, prospective payments are more predictable.

The current payment method for radiology services fails to achieve this goal. Hospitals are paid, by law, the lesser of costs (or charges, for those hospitals with charges below costs) or a blended amount, which equals 42 percent of hospital-specific costs and 58 percent of 62 percent of the global fee schedule amount. This method provides no incentive for hospitals to lower their costs because it simply reduces payments rather than establishing a reward system for hospitals that deliver care more efficiently. By contrast, physicians are reimbursed on the basis of a prospective fee schedule for the same service, thereby encouraging them to control costs.

Physician-provided radiology services have been paid on the basis of a fee schedule for several years. The original fee schedule was based on a professional services component and a technical component. The professional component measured the physician's time, skill, and intensity of service. The technical component measured the physician's practice costs—rent, employee salary, and equipment costs, and so forth. When constructed, it was assumed that 62 percent of the physician's charge

for radiology services represented the technical component. Therefore, payment for hospital-provided radiology services was based on the same percentage.

Beginning January 1, 1992, payments to all physicians are based on the Medicare Fee Schedule. Radiology services are incorporated into this fee schedule. It also includes professional and technical components. However, the technical component has been refined to measure practice costs for individual radiological procedures more accurately. ProPAC believes, therefore, that the technical component of the new physician fee schedule should be used to calculate payments for individual hospital outpatient radiology services.

In ProPAC's view, payment rates should recognize justifiable differences in the costs of furnishing services. Costs may differ between hospitals and free-standing providers for several reasons, including patient severity, standby capacity, and the presence of an emergency room. While data are not available to measure radiology service costs in free-standing settings, payment rates vary between these settings and hospitals. Despite the lack of information explaining these differences, the Commission believes that the hospital payment rate should incorporate a portion of the payment difference. ProPAC acknowledges that radiology services provided in physicians' offices are comparable to those provided in the hospital outpatient setting, to some degree. Therefore, the national payment rate should also reflect physician payments.

The national payment rate for radiology services furnished in the hospital setting should be computed using average hospital costs and the technical component of the Medicare Fee Schedule for physicians. Preliminary analysis indicates that about 10 percent of hospitals currently receive payments based solely on costs. This indicates that these hospitals' costs are lower than the comparable physician payments. Eliminating the "lesser of" provision in current law and reimbursing these hospitals using rates calculated with the current blended rate would increase Medicare expenditures. Therefore, the Secretary should adjust the national rates to maintain budget neutrality. ProPAC's preliminary estimates indicate that the national rate will reflect a 36:64 blend of average hospital costs and the technical component of the Medicare Fee

Schedule for physicians. These rates should be updated annually to reflect changes in the market basket and other appropriate cost increases.

Better cost data are necessary to determine the reasons for and the magnitude of cost differences between settings to understand the implication of using the technical component of the current physician fee schedule. (See Recommendation 15.) Future payment rates could be adjusted to reflect better cost data. Finally, the Commission believes that these national rates should be adjusted to reflect differences in wages. (See Recommendation 21.)

Recommendation 21: Payment Adjustments for Hospital-Provided, ASC-Approved Surgery and Radiology Services

The Commission believes that national prospective payment rates for ASC-approved ambulatory surgery and radiology services should be adjusted to reflect differences in labor costs. This adjustment should take into account the appropriate labor share and occupational mix of ASC-approved surgery and radiology services in the hospital outpatient setting. The Secretary should conduct additional research to determine whether other adjustments are warranted.

The Commission supported the concept that the payment system should be neutral with respect to certain providers, settings, and area characteristics. The payment system should not inappropriately influence the site where services are furnished.

ProPAC's recommendation for payment of ASC-approved surgical procedures and radiology services furnished in hospitals incorporates hospital costs to reflect differences between hospitals and other ambulatory care providers. These rates should also be adjusted to reflect differences among geographic areas. Payments to free-standing providers and physicians are now adjusted for differences in area wages. To ensure equity among providers located in various areas of the country, as well as maintain consistency with other payment methods, payments for hospital outpatient services should also account for variations in area wage levels.

The proportion of costs attributed to labor and the mix of occupations employed differs between the outpatient and inpatient settings. Under PPS, for example, 71 percent of the standardized amount is adjusted for the cost of labor. Conversely, in free-standing ASCs, about 35 percent of the rate is labor adjusted. Therefore, the labor share and the wage index used for inpatient services may not be appropriate for outpatient services.

If the labor share were less for outpatient services than for inpatient services, reimbursing outpatient services based on the inpatient labor share would tend to overpay hospitals in higher wage areas (urban); it would underpay those in lower wage areas (rural). In addition, the over-adjustment would tend to obscure other differences in outpatient costs that are associated with an urban location, such as teaching or disproportionate share status.

Further, if the mix of occupations employed in the outpatient setting differed from the overall facility mix, using the hospital wage index for an outpatient payment system would lead to inaccurate payments for outpatient services. The complexity of services and the resulting differences in the occupational mix in inpatient and outpatient settings may vary considerably. The Secretary should undertake research to determine and adjust for the appropriate labor share for outpatient services, as well as the mix of occupations employed in outpatient settings.

Besides variations in costs due to geographic location, costs may differ among hospital groups. Under PPS, payment adjustments account for these differences. The need for additional payment adjustments for hospital groups, such as those to teaching, disproportionate share, and sole community hospitals, should be evaluated. Preliminary analyses indicate that average hospital costs for radiology and ASC-approved surgery did not vary substantially for hospitals with teaching or disproportionate share status. These costs did, however, appear to vary by hospital size and geographic location. Rural hospitals had lower costs than hospitals in urban areas, and larger hospitals had lower costs than smaller ones. While size appears to influence costs, multivariate analysis should be conducted to consider, simultaneously, teaching, location, disproportionate share status, and size.

Once these analyses are complete, the need for and the amount of adjustments can be determined.

Improving Skilled Nursing Facility Payment Policy

OBRA 1990 requires the Secretary and ProPAC to report on a prospective payment system for extended care services provided in skilled nursing facilities. The Secretary was charged with developing a proposal to modify the current system or, alternatively, to develop a proposal to pay for skilled nursing care on the basis of prospectively determined rates. The Secretary was to have issued the report by September 1, 1991, but has not yet done so.

ProPAC was to have commented on the Secretary's report by March 1, 1992. Instead, the Commission is issuing a background report on skilled nursing facility payment by the March deadline, and will review the Secretary's SNF payment proposal after it has been released. The following recommendation and discussion are excerpted from ProPAC's forthcoming report.

Recommendation 22: Nursing Facility Wage Index

The Secretary should collect data on employee compensation and paid hours of employment for nursing facilities that care for Medicare SNF patients. Once these data become available, the Secretary should develop a nursing facility wage index and use it to adjust Medicare SNF payments.

The current Medicare SNF payment system uses the hospital wage index to adjust payments. However, there is evidence to suggest that geographic differences in the unit prices of labor for hospital employees are not similar to those for employees of nursing facilities. ProPAC simulated a nursing facility wage index with limited data and found significant differences from the hospital wage index. For example, the HCFA hospital wage index is much lower than the estimated nursing home wage index in urban areas of the New England and Mid-Atlantic states and higher in the West South Central region.

These indexes may differ due to wide variations in state regulations affecting nursing homes. Through their certification and oversight roles, states have a

major impact on the costs and staffing of nursing facilities. It is appropriate for Medicare to recognize these differences in labor costs imposed by the states. Increased Federal involvement through OBRA 1987 may reduce variations in state regulations that affect nursing homes. This legislation provides for far greater Federal oversight of nursing homes. OBRA 1987 also mandates new standards for quality of care in these facilities, requirements related to overall staffing, and minimum training for nurse aides.

Another potential reason for the failure of the hospital wage index to reflect adequately the variation in skilled nursing facility wages is the skill mix differences between hospitals and nursing facilities. Nursing facilities employ proportionately more aides than hospitals. In addition, the relative level of aides' salaries compared with nurses' salaries may not be the same across geographic areas. The hospital wage index does not capture these differences in the mix of employees and in relative wages.

The use of the hospital wage index under the current system contributes to inequitable Medicare SNF payments across regions. The relationship of payments to costs varies significantly by geographic area. For example, almost half of the facilities in New England and almost a third of those in the Mid-Atlantic region receive less than 85 percent of their costs. This compares with an average of only 45 percent of the facilities in other regions. In addition, only 17 percent of the facilities in New England and 30 percent in the Mid-Atlantic region receive 100 percent of their costs, compared with 66 percent of the facilities in the West South Central region and 50 percent in the Pacific region.

Regardless of the payment method for nursing facilities under Medicare, an accurate wage index is necessary to account for geographic differences in wages. As with the hospital wage index, the method used to collect wage and hour data for nursing facilities should be prospective and incorporated with the current Medicare Cost Report to maximize the consistency of the data and minimize the reporting burden. Further, the Commission suggests that the Secretary phase in the use of the nursing facility wage index to allow time for facilities to adjust.

The Commission also recognizes that collecting nursing facility wage data and developing an index

may take several years to complete. As an interim measure, separate cost limits could be developed for each geographic region. This would partially address the problems associated with the use of the hospital wage index.

Recommendation 23: Nursing Facility Case-Mix Adjustment

The Commission believes that the payment system should recognize differences in the costs of care for different types of patients. Therefore, it supports the Secretary's efforts to develop and implement a case-mix adjustment to Medicare SNF payments under the Multistate Nursing Home Case Mix and Quality Demonstration. If the case-mix adjustment developed under the demonstration proves to be appropriate, it should be implemented.

Under the current Medicare SNF payment method, skilled nursing facilities face a financial disincentive to admit Medicare patients, especially those who require the most care. Medicare beneficiaries are often sicker and require more nursing and rehabilitative care than other SNF patients. The current Medicare method of cost finding, however, attributes routine costs (including nursing care costs) to Medicare on the basis of the program's share of patient days. That is, Medicare patients and other nursing facility patients are treated as if they all incurred the same average per diem cost for routine care services. As a result, Medicare's share of allowable costs tends to understate the true costs of caring for Medicare patients. Further, this discrepancy, and the related financial disincentive, may be especially large for Medicare beneficiaries who require more than average care. A payment adjustment that explicitly recognized differences in cost for different types of patients would mitigate the disincentive to admit patients who require more extensive care.

A case-mix index is being developed under the Multistate Nursing Home Case Mix and Quality Demonstration. This demonstration, which is being conducted in six states, will use the index for Medicare and Medicaid payment and evaluate its performance. If the case-mix adjustment developed under the demonstration proves to be appropriate, it should be implemented.

federal register

**Thursday
June 4, 1992**

Part III

Department of Agriculture

**Agricultural Stabilization and Conservation
Service**

**7 CFR Part 703
Wetlands Reserve Program; Final Rule**

DEPARTMENT OF AGRICULTURE

Agricultural Stabilization and Conservation Service

7 CFR Part 703

Wetlands Reserve Program

AGENCY: Agricultural Stabilization and Conservation Service, USDA.

ACTION: Final rule.

SUMMARY: Title XIV of the Food, Agricultural, Conservation, and Trade Act of 1990 (the 1990 Act), enacted on November 28, 1990, amended the Food Security Act of 1985 (the 1985 Act) to provide for the establishment of the Wetlands Reserve Program (WRP). The 1990 Act amendments authorized the Secretary of Agriculture to purchase easements from owners of eligible land who voluntarily agree to restore and protect farmed wetlands or converted wetlands and eligible adjacent acres. For fiscal year 1992 only, the WRP shall be available to producers in only the following states: California, Iowa, Louisiana, Minnesota, Mississippi, Missouri, New York, North Carolina, and Wisconsin. This final rule adopts, with changes, the proposed rule published in the *Federal Register* (57 FR 4378) on February 5, 1992, which set forth the proposed regulations which are necessary for the implementation of the program.

EFFECTIVE DATE: June 1, 1992.

FOR FURTHER INFORMATION CONTACT: James R. McMullen, Director, Conservation and Environmental Protection Division, ASCS, P.O. Box 2415, Washington, DC 20013; phone (202) 720-6221.

SUPPLEMENTARY INFORMATION: This final rule has been reviewed under USDA procedures established in accordance with Executive Order 12291 and provisions of Departmental Regulation 1512-1 and has been classified as "major." It has been determined that these provisions may result in an annual effect on the national economy of \$100 million or more. However, (1) no major increases in costs or prices for consumers, individual industries, State or local agencies, or geographic regions, or (2) significant adverse effects on competition, employment, investment, productivity, innovation, or the ability of the United States-based enterprises to compete with foreign-based enterprises in domestic or export markets will result upon implementation of these provisions. However, a regulatory impact analysis has been prepared and is available upon request.

It has been determined that the Regulatory Flexibility Act is not applicable to this rule since Agricultural Stabilization and Conservation Services (ASCS) is not required by 5 U.S.C. 553 or any other provision of law to publish a notice of proposed rulemaking with respect to the subject matter of this rule.

It has been determined by an environmental assessment that this action will not have any significant adverse impact on the quality of the human environment. Therefore, an environmental impact statement is not needed. Copies of a final environmental assessment are available upon request.

This program/activity is not subject to the provisions of Executive Order 12372 which requires intergovernmental consultation with State and local officials. See notice related to 7 CFR part 3015, subpart V, published at 48 FR 29115 (June 24, 1983).

The title and number of the Federal Domestic Assistance Program, as found in the Catalog of Federal Domestic Assistance to which this rule applies are: Wetlands Reserve program 10.072.

The information collection requirements of the final rule at 7 CFR part 703 have been submitted to OMB for approval under provisions of 44 U.S.C. chapter 33. Further, the OMB number 0560-0139 has been assigned.

The public reporting burden for the information collections that would be required for compliance with these regulations is estimated to average 31 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information.

This final rule has been reviewed in accordance with Executive Order 12778. The provisions of this final rule: are not retroactive; and preempt State and local laws to the extent such laws are inconsistent with the provisions of this final rule. Before an action may be brought in a Federal court of competent jurisdiction, the administrative appeal rights afforded program participants at 7 CFR part 780 must be exhausted.

Discussion of Program

The WRP is authorized by title XII of the 1985 Act. Under the WRP, the Agricultural Stabilization and Conservation Service (ASCS) will purchase easements from persons voluntarily agreeing to restore farmed and converted wetlands. The 1990 Act creates an umbrella program called the Agricultural Resource Conservation Program (ARCP) which includes the Environmental Conservation Acreage Reserve Program (ECARP). ECARP

includes the Conservation Reserve Program (CRP) and the WRP. On April 19, 1991, the Commodity Credit Corporation published a rule in the *Federal Register* (56 FR 15980) containing final regulations which would add to the Code of Federal Regulations a new part (7 CFR part 1410) for the CRP program. General provisions for the ARCP were included as subpart A of part 1410 and specific regulations for the CRP were set out as subpart B. This rule establishes a new part (7 CFR part 703) for WRP.

Maximum Acreage Enrollment, Land Eligibility, and Easement Priorities

Section 1237 of the 1985 Act sets a 1991-95 enrollment goal of a maximum 1 million acres for the WRP, but provides further that enrollment through 1991 may not exceed 200,000 acres, enrollment through 1992 may not exceed 400,000 acres, enrollment through 1993 may not exceed 600,000 acres, enrollment through 1994 may not exceed 800,000 acres, and enrollment through 1995 may not exceed 1,000,000 acres.

Section 1237 specifies that eligible land will include farmed or converted wetlands, but not wetlands converted after December 23, 1985, together with adjacent lands on which the wetlands are functionally dependent so long as the likelihood of successful restoration of such land and the wetland values merit inclusion in the program taking into account the cost of restoring the wetlands. ASCS is also permitted to include in the program: (1) Farmed wetlands and adjoining lands that are enrolled in the CRP with the highest wetland functions and values and that are likely to return to production at the end of the CRP contract; (2) other wetlands that would not otherwise be eligible if it is determined that inclusion in the program would add to the value of the easement; and (3) riparian areas that link wetlands that are protected by easements or by some other device or circumstance that achieves the same purpose as an easement. In addition, prior converted wetlands enrolled in the CRP may be eligible to be included in the WRP if there is a high probability the wetlands can be restored.

Nationwide, eight pools will be established that correspond with the country boundaries of Soil Conservation Service's (SCS) Major Land Resource Regions (MLRR's). Bids accepted, generally, will be based on a ratio of acres of hydric cropland soils in a particular pool area compared to the acres of hydric cropland soils in the nation. If bids are not accepted which equal the total allocated acreage within

a pool area, ASCS may, at ASCS's discretion, redistribute any remaining acreage in such pool to other pools. Section 1237 prohibits acquiring WRP easements for land that contains timber stands established under the CRP.

With respect to owner eligibility, section 1237E of the 1985 Act provides that no WRP easement shall be created on land that has changed ownership in the preceding 12 months unless: (1) The new ownership was acquired by will or succession as a result of the death of the previous owner; or, (2) the Secretary determines that the land was acquired under circumstances that give adequate assurances that such land was not acquired for the purpose of placing it in the WRP.

Section 1237A provides that the easements purchased under the WRP shall be in a recordable form and shall be for 30 years, permanent, or the maximum duration allowed under applicable State laws. Section 1237C(c) provides that in determining the acceptability of offers, consideration may be given to the extent to which the purposes of the program can be accomplished on the land, the productivity of the land and the on-farm and off-farm environmental threats if the land is used for the production of agricultural commodities. In addition, section 1237C(d) provides that to the extent practicable, taking into consideration costs and future agricultural and food needs, the Secretary shall give priority to obtaining permanent easements before shorter term easements and, in consultation with the Secretary of the Interior, shall place priority on acquiring easements based on the value of the easement for protecting and enhancing habitat for migratory birds and other wildlife. In order to accomplish this goal, § 703.12 provides that permanent easements will be preferred whenever possible. The final rule at § 703.10 provides that the duration of the easement is one of the factors which will be evaluated in rating bids to be accepted into the program. ASCS's intention is that a bid which offers less than a permanent easement shall be substantially lower in priority than a bid offering a permanent easement. For fiscal year 1992 and subsequent enrollment periods, requirements regarding the duration of WRP easements shall be as announced by ASCS.

A formula will be used to determine a ranking for bid acceptance when an excess of eligible bids are received during any given signup period. ASCS's intention in ranking the bids is to enroll the wetlands that provide the greatest

environmental benefits for the government money expended on restoration and easement purchase. Initially, the prioritization formula will emphasize factors that ensure the effectiveness of the restored wetland when compared to a site's particular wetland functions and values. The weight of particular factors may change if credible new information is developed that characterizes the environmental benefits of wetlands by their specific functions and values.

Further, if it is determined that special circumstances exist which increase the value of the area to be accepted and the wetland to be restored, the SCS State Conservationist, upon the recommendations of the Fish and Wildlife Service (FWS) and the local SCS office, may request acceptance of no more than five percent of the total acreage enrolled in the State during each signup period irrespective of the ranking. Each request for such acceptance will be considered on a case-by-case basis taking into consideration the information submitted by SCS for each such request.

Successful permanent easement bidders have an option of either receiving lump-sum payments or equal annual payments over 10 years. For bid evaluation purposes, the net present value of a lump-sum bid will be calculated to equitably compare the two options to ensure that the maximum environmental benefit per taxpayer dollars expended is obtained.

The final regulations implement the owner and land eligibility provisions in §§ 703.8-703.9. In order to assure maximum benefits from the expenditure of WRP funds, the regulations set out crop-history requirements and other provisions which include limiting the eligibility of "adjacent lands" to buffer areas that in each case may neither, for the particular easement, average more than 100 feet wide nor be more than twice the area of the restored wetland. Landowners will be allowed to transfer eligible land from the CRP to WRP during the first 2 WRP sign-up periods established in their county without having to refund CRP payments or having to accept a reduction of their WRP payment. Transferring eligible land from CRP to WRP after the first 2 WRP sign-up periods will result in a reduction in any WRP amount due equal to any CRP payments received after the second available WRP sign-up period.

Specifications are also set out in the final regulation for the wetland functional values which may be considered relevant by ASCS in determining whether particular parcels

should be accepted for enrollment in the program. Sections 703.10-703.11, provide for a bid system to be used to determine enrollment and those sections provide for the use of priorities in assessing bids, as is provided in the statute. Section 703.12 provides specifically that, to the extent practicable, all easements shall be permanent easements unless it is determined by ASCS upon evaluation of offers that accepting an offer for a shorter period, which still meets the minimum length requirements of the 1985 Act, is necessary for accomplishment of the national program goals in individual cases.

With respect to fiscal year 1992 only, WRP shall be available to producers only in the following states: California, Iowa, Louisiana, Minnesota, Mississippi, Missouri, New York, North Carolina, and Wisconsin. These states have been determined to be those which will provide the eligible acres necessary to enroll approximately 50,000 acres and allow an evaluation of WRP implementation procedures.

Producer Requirements

Section 1237A of the 1985 Act provides that an owner of land placed in the program must: (1) Grant an easement on the land; (2) implement a Wetlands Reserve Plan of Operation (WRPO); (3) provide for the creation and recordation of a deed restriction covering the easement area; and (4) ensure consent to the easement from persons holding a security interest in the property.

The 1985 Act requires, in addition, that the easement permit: (1) Repairs, improvements, and inspection on such lands that are necessary to maintain existing public drainage systems and; (2) landowners to control public access on the easement area while identifying access routes to be used for wetland restoration activities, management and monitoring. Section 1237A requires that the easement: (1) Prohibit the alteration of wildlife habitat and other natural features of the land unless specifically permitted by the WRPO; (2) prohibit spraying with chemicals or mowing of the land except as permitted by the WRPO to comply with Federal or State noxious weed laws or Federal or State emergency pest treatment programs. The 1985 Act provides further that the Secretary may impose other conditions as needed and authorizes the Secretary to permit compatible uses of the property which are deemed consistent with the primary purposes of the easement. Section 1237B requires, generally, that participants must comply with all program requirements and specifies that as a condition for

participation, the participant must agree to the permanent retirement of any existing cropland base and allotment history for such land under production adjustment programs administered by the Secretary.

Section 1237A provides that in the case of any violation of the terms and conditions of the easement or related agreement, the easement shall remain in force and the owner may be required to refund all or part of any payment made for such easement, together with interest. With respect to WRPO's, section 1237A provides that such WRPO's will be developed and agreed to at the local level by representatives of the SCS and the FWS, United States Department of Interior, in conjunction with the landowner. However, if agreement between SCS and FWS cannot be reached at the local level, the WRPO shall be developed by the State Conservationist in consultation with FWS.

Sections 703.12 and 703.15 set out the obligations of WRP participants. These provisions require participants to control noxious weeds or pests to the extent specified in the WRPO taking into consideration the needs of wildlife and water quality. Each participant will be required, prior to submitting a bid for participation in the program, to have an approved WRPO which would set out the manner in which the land would be restored to a wetland status and other measures which would be required for the property including adjacent areas.

Under § 703.12 participants are required to be responsible for the long-term management of the easement in accordance with the terms of the easement and related agreements including the WRPO. However, participants will continue to have the option, at their sole discretion, to enter into an agreement with a Federal, State, or private conservation entity to secure management assistance or other commitment of action from such entities that the landowner determines to be in their interest. Arranging for a conservation entity to become the owner of record of the land, including the management responsibilities associated with the easement area, is one potential option available to the present owner as a means of transferring long-term management responsibility.

Section 703.15 sets out provisions which authorize ASCS to permit certain uses to be considered compatible uses of the property in appropriate cases. Those uses can include fee hunting and fishing, and, in addition, timber production under an approved management and harvesting plan.

Compatible uses may also include haying or grazing if allowed by the WRPO in a manner consistent with the easement. Provisions for remedies for ASCS in the event of a program or easement violation are set out in § 703.19 of the final regulations.

Payments

WRP payments are subject to advance appropriations. ASCS may make easement payments, cost-share payments and reimbursement for fair and reasonable legal costs associated in acquiring an easement. With respect to easement payments, section 1237A of the 1985 Act provides that the easement payment may not exceed the amount which is equal to the difference between the fair market value of the land less the fair market value of the land encumbered by the easement. Easements will be accepted based on the market value of the agricultural land. A formula to determine the value of the land will be used based on the average market value of agricultural land in a county adjusted for: (1) Soil productivity, (2) landowner cost of wetland restoration; (3) long term easement area operation; maintenance, and replacement costs; (4) long term costs of providing for an easement access route; and (5) any other factors authorized by ASCS. This section provides further that the payments may be made on an annual basis, in equal or unequal amounts, for a period which may not be less than 5 years or more than 20 years. This section also provides: (1) In the case of permanent easements, a lump-sum payment may be made; and (2) that the total amount of easement payments made to a person for any year under the WRP may not exceed \$50,000, except that such limitation will not apply with respect to payments for permanent easements. With respect to cost-share payments, section 1237C of the 1985 Act provides that, for non-permanent easements, the Secretary shall authorize cost-shares equal to not less than 50 percent nor more than 75 percent of the cost of carrying out the establishment of restoration measures and practices and the protection of the wetland functions and values, as set forth in the WRPO, to the extent that the Secretary determines that cost-sharing is appropriate and in the public interest. At § 703.13 the final rule provides that cost sharing for easements which are less than permanent may receive cost shares at a rate as low as 50 percent while easements which are permanent may receive cost shares at a rate which is no less than 75 percent of eligible costs. It is ASCS's intention to use a 50 percent

cost share rate on less than permanent easements and a 75 percent rate on permanent easements.

Unlike CRP participants, WRP participants are not subject to the wetland conservation and highly erodible conservation provisions of Title XII of the 1985 Act under which participants may lose eligibility for certain USDA benefits as the result of prohibited activities related to wetlands and highly erodible lands. Section 1237D of the 1985 Act provides that WRP payments are not subject to a budget sequester order issued under section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985.

Provisions for payments are made in § 703.13. Those provisions specifically authorize withholding a portion of the easement payments otherwise due pending installation of the practices agreed to in the WRPO. In addition, the final rule provides that cost-share payments may be made under the WRP for the establishment or installation of the eligible restoration practices or reestablishment or reinstallation if failure is due to an unforeseen natural disaster or similar act. With respect to the limitation on payments for non-permanent easements, § 703.14 provides that payment limitation determinations will be made in accordance with 7 CFR part 1497 (including § 1497.109(a)) which provides that payments will be attributed to each member of an entity.

Miscellaneous Provisions

The final regulation contains other miscellaneous provisions to implement the program provided for in the 1985 Act. These provisions cover, among other matters, assignments of payments, the transfer of the enrolled property, and the enrollment limitations of 25 percent of the county cropland. In the case of a land transfer, the easement will "run with the land;" therefore, all parties having or acquiring an interest of any kind in the property are subject to the easement. Section 703.4 of the final rule provides for the acceptance of long term easement offers in counties where cropland enrollment into ECARP already exceeds 25 percent of the county's cropland.

Discussion of Comments

ACSCS received sixty-nine letters containing 274 comments concerning the proposed rule published February 5, 1992. Entities responding included individuals, State governments, local governments, State wildlife and conservation organizations, national wildlife and conservation organizations, national farm and commodity

organizations, and Members of Congress. Comments came from twenty-eight states and that District of Columbia.

Changes in this final rule from the proposed rule of February 5, 1992, are based upon public comments to the proposed rule. A few minor editorial and other changes have also been made in the text for clarity and to facilitate the application of the regulations. The discussion of comments that follows is organized by section in the same sequence as the final rule.

Section 703.1 Applicability

Twenty-eight comments were received regarding the proposal to limit the implementation of WRP in the fiscal year 1992 to 8 states. The respondents indicated that other States and types of restored wetlands are desirable to be included as pilot States. Although an argument can reasonably be made for the inclusion of any specific State based on local conditions, only one State, Wisconsin, was added. Implementation of the CRP in Wisconsin provides a unique opportunity to study the effects that an existing State restoration program, that in over 20 years has established over 1,500 wetlands in the State, may have on participation in the new WRP. Wisconsin also ranks high in potential hydric soils suitable for restoration to better ensure sufficient bids are submitted in order to reach the 50,000 acre goal during the pilot program.

Section 703.2 Administration

Nineteen comments suggested changes in the proposed administration of the WRP. These comments addressed the issues of the roles and responsibilities of environmental and conservation groups in implementing the WRP. Several minor editorial and other changes have been adopted. Accordingly, the provisions of § 703.2(f)2 have been expanded to include consultation with State and non-governmental organizations at the State and local level; the provisions of § 703.12(a)15 have been clarified to include private organizations; and § 703.15(d) to include conservation districts as approving officials on the WRPO. Designating a different lead agency or requiring the local drainage district as an approving official are not viable alternatives and were not adopted. Although ASCS is the administering agency, the success of this program lies with the technical agencies, namely SCS and FWS, that will make the technical decisions regarding land eligibility and development of the WRPO with the landowner, and FS

where tree planting for timber production is approved.

Section 703.3 Definitions

One comment suggested that the term "non-permanent easements" include 10-year agreements. The 1985 Act provisions specifically state the types of easements which may be accepted and the length of the easements. There is no statutory basis to adopt this suggestion.

One comment recommended expanding program provisions to specify the role and function of environmental and conservation organizations at the local level. These organizations are important and expected to play a major role in the effective implementation of the WRP. Section 703.3 has been amended to specify that ASCS will consult with non-governmental agencies regarding issues when necessary and appropriate.

Another comment requested that trees and vine crops be included in the definition of an agricultural commodity. Generally, for the purposes of this program, an "agricultural commodity" is defined to be an annually tilled crop or sugarcane. Adding trees or vine crops would go beyond that criteria and would not generally produce the same public benefit as the enrollment of other lands into the program. Accordingly, no change has been made by the final rule.

One comment offered another definition for "riparian areas." In response to this comment an addition to the proposed definition has been included in § 703.3 to expand the definition of a "riparian area" to provide that areas along "channels" shall also be included.

Finally, one comment pointed out the proposed definition of an "easement area" included only the land being restored and not necessarily the adjacent lands. The definition of "easement area" has not been revised, since the term is used to delineate that portion of the farm on which the restored wetland is located, or which is described on the easement document as being the location of the required practices necessary to restore the hydrology and protection to the restored area. However, the easement document will specify that no action may be undertaken anywhere on the easement farm which affects the restored wetland or other area designated as the easement area.

Section 703.4 Maximum County Acreage

Three comments were received favoring a waiver of the 25 percent maximum cropland permitted to enter into the Environmental Conservation

Acreage Reserve Program (ECARP) and one comment was received opposing any waivers. Since long-term easements are preferred over shorter-term easements and CRP contracts will begin expiring in 1996, it has been determined ASCS may accept and approve offers in counties in excess of the 25 percent cropland rule when such acceptance is deemed not to have an adverse effect on the local economy. The final rule has been modified to reflect that ASCS will accept WRP intentions and a waiver be granted in order to accept acreage into the WRP in an amount which is in excess of 25 percent of the county's cropland.

Section 703.6 Eligible Person

Six comments recommended waiving or eliminating any ownership requirement. One comment opposed allowing a person to purchase farmland solely for the intent of enrolling such land into the WRP. The proposed rule has been adopted without change since experience with the CRP has shown that program abuse is likely to occur if there is no prior ownership requirement.

Section 703.7 Eligible Land

Twenty-eight comments were submitted for review and consideration. Four of these were from California, recommending the cropping history requirement be modified or eliminated so as to permit the eligibility of pasture land for inclusion into the WRP. Since only slight to moderate enhancement of wetland functions and values would be achieved, this provision was not amended regarding cropping history.

Other comments recommended expanding the "adjacent area" which may be included in an easement from the average of 100 feet set forth in the proposed rule to 300 feet or to cover an entire watershed. Based on the advice provided by representatives of the technical agencies, the proposed 100 feet provision provides the nesting habitat and the restored area will be adequately protected from siltation or other water quality contaminants without defeating the intent of the program which is to restore wetland hydrology. ASCS does not believe that the additional acreage is necessary to achieve WRP goals. Therefore, no change was made in this regard.

Three comments suggested placing a higher priority for acceptance on eligible riparian areas. Five comments were supportive of the riparian area criteria, buffer area inclusion, or supported the eligibility criteria "as is." Other comments suggested including as eligible areas, areas with trees;

bottomland hardwoods; or habitats for threatened or endangered species. These comments generally went beyond the scope of the WRP by including sizable increases in non-hydric cropland areas. Therefore, except as noted in the discussion on changes to § 703.8, none of these suggested changes were adopted.

Section 703.8 Additional Land Eligibility Provisions

One comment recommended inserting for inclusion "land including pasture lands or adjacent lands that have been identified as being habitat of an endangered or threatened species." The suggestion was not adopted; however, § 703.10(d) is being modified to allow for additional consideration under easement priority for wetlands which may aid in the protection of threatened or endangered species.

Section 703.9 Transfer of Lands From the CRP to the WRP

Thirteen comments were received with respect to the issue of allowing current CRP contract holders to enroll eligible land in the WRP prior to the maturity of the CRP contract. Generally, these comments opposed the proposal requiring CRP participants to bid in the first available WRP signup period; those CRP participants who did not bid at that time would have to wait until their CRP contract terminated before a WRP bid could be submitted. These comments also opposed the manner in which ASCS proposed to take into account previously paid CRP payments when making the WRP payments with respect to land subject to both contracts. In response to these comments, ASCS will allow CRP participants the opportunity to submit a WRP bid during all WRP signups; however, any CRP payment which is made after the second WRP signup period available to the CRP participant will be deducted from the WRP payment made to such person. This will allow for greater WRP participation without defeating the purposes of either program while ensuring that limited funding is used to the maximum possible extent.

Section 703.10 Easement Priority

Seventeen comments were received. Three comments support the use of a formula for selection purposes. One comment stated the formula was too complex. One comment recommended deleting the formula. Two other comments recommended either including the formula in the rule or providing copies of the formula to eligible landowners. One comment felt it was unfair to stress permanent easements. Two comments

recommended that ASCS provide appraisals for review while one commenter was concerned how land values will be established. Another comment suggested expanding criteria to include North American Waterfowl Management Plans. One comment believed the prioritization should be the function of the technical agencies and not ASCS. In order to ensure that proper weight is given to all bids and to ensure that all factors involving the offered area are given sufficient consideration, a formula or other internal guidance is needed for use by ASCS personnel. Experience with prior ASCS administered programs has shown that disclosure of all criteria used in the bid evaluation process is not feasible and also defeats the whole concept of a bid program. Accordingly, these suggestions were not adopted except that the factor for "wetlands location significance" was clarified to include the contribution that restoration of the wetland may make toward the recovery of threatened or endangered species.

Section 703.11 Statement of Intention; Submission of Bids

Seven comments were received with six expressing concern over the most beneficial use of technical agency time in working with potential WRP participants. Each of the six comments recommended using "draft" Wetland Reserve Plans of Operation (WRPO) or not requiring any actual planning until after a producer had enrolled into the WRP. SCS has agreed to furnish a comprehensive plan to the landowner for assistance in formulating a competitive bid based on out-of-pocket costs to be incurred and any rights afforded under the easement such as haying, grazing, fee hunting, or planned timber harvest. The WRPO is a tool to bid competitively for acceptance into the program. However, detail design plans may not be completed by the technical agency until the bid is accepted. ASCS and SCS believe anything less than full disclosure as to requirements, costs, and rights retained would be unfair to a landowner and could cause increased program costs if any uncertainty existed. In addition, in order to properly prepare the easement document, the producer and ASCS must have a firm agreement as to the action to be undertaken or prohibited on the easement area and easement farm. For these reasons, this suggestion has not been adopted.

The seventh comment recommended providing copies of easement forms and other relevant forms to producers at the time of submission of an intention to participate. Any person may request and

receive a copy of the WRP forms at any time. Each landowner signing an intention to participate will be given a packet of information including a basic easement document at that time to ensure a thorough understanding of the WRP and to assist in the formulation of a bid after the WRPO is completed.

Section 703.12 Obligations of the Landowner

Fifty-three comments were submitted for review and consideration on this section. Fourteen of these were regarding the length of easement. Most were strongly supportive toward permanent easements and did not support the use of short-term easements. Due to the limited funding available and due to the highest returns to be gained from these funds, it has been determined that ASCS will only accept permanent easements unless otherwise announced by the Deputy Administrator, State and County Operations, ASCS.

Eleven comments recommended changes for clarity with respect to permissive and restrictive uses in the adjacent areas of a participant's farm not included in the easement area. This suggestion is adopted in the final rule; § 703.12 is revised to provide that the WRPO will specify the prohibition of any activity that will cause excessive sedimentation or contaminants to enter the easement area or that may alter the flow of surface or subsurface water.

Five comments recommended deleting the requirement to control pests and weeds on the easement area. Two comments were concerned on the use of pesticides in weed or insect control. One comment suggested that the WRP regulations should take into account that the creation of wetlands through restoration may create nuisance problems in some instances. ASCS deemed no change is needed since State and local laws are applicable to the easement area.

Section 703.13 Payments to Landowners by ASCS

Thirteen comments were received. Three comments recommended clarifying the provisions of the regulations concerning easement cost and filing cost responsibilities. The final rule has been clarified to specify that ASCS will reimburse participants for fair and reasonable costs concerning title search and filing costs.

Five comments recommended higher cost-share rates. One comment suggested including as an eligible cost any water requirements in arid areas. One comment recommended lump-sum payments be offered to owners offering

less than permanent easements. Another comment disagreed with the proposal to refrain from making total payment until completion of practices necessary for restoration. These comments were not adopted since the 1985 Act specifically limits lump-sum payments to only those landowners granting a permanent easement and extending the benefits beyond that proposed would not be maximizing the possible program extents.

Finally, one comment recommended that the regulations clearly provide that landowner's be made aware that the WRP was funded by advance appropriations for the total value of the easement prior to ASCS accepting any offers. This suggestion was not adopted since it was determined that the issue is not one properly addressed in a regulation; however, participants may be fully apprised of their rights with respect to receiving payments by contacting their county ASCS office.

Section 703.15 Wetland Plan of Operations

Thirty-two comments were offered for consideration regarding the WRPO. Many of the comments recommended that the regulations be expanded to clarify those actions which are covered by the WRPO. Other comments related to the proposed provisions regarding weed control. With some comments recommending stricter provisions concerning the landowner's responsibilities, other comments recommended deleting the requirement of weed control entirely.

Many of the comments addressed the appropriateness of including grazing, haying, and mowing. Several comments recommended that the WRPO also be signed by State agencies and local drainage districts. There was also concern that the WRPO submitted with the bid not be so detailed that it burdens the landowner or the agencies preparing the WRPO.

The regulations have been expanded to address or clarify some of the above concerns. Specifically, the landowner will be assisted by the SCS, FWS, and other appropriate agencies in the preparation of the WRPO, therefore, the development of the WRPO will not demand a great deal of the landowner's resources. Although the WRPO is a comprehensive document, details regarding restoration designs and subsequent operation and maintenance will be developed following bid acceptance. In addition, the WRPO development allows for State agencies and drainage districts to be consulted by SCS while developing the WRPO.

The WRP allows for haying, grazing, timber harvesting, and hunting and fishing, if determined by SCS and FWS that such use is compatible with the goals and objectives of the program. Specific guidelines concerning compatible uses will be site specific and agreed to by the landowner, SCS, FWS, and ASCS before bid acceptance.

Section 703.16 Easement Modifications

Four comments were received. Two comments recommended prohibiting any blanket waivers for haying or grazing of the easement area during an emergency. Because the WRP easements may be perpetual in nature and due to the fact that it is not possible to foresee the possible feed needs of landowners in an emergency situation, the regulations do not prohibit such action. However, any such approval would be made only in those instances in which ASCS has determined that adverse affects to the easement area would not occur. One comment recommended concurrence by FWS and SCS and plan modifications. SCS and FWS will concur on plan modifications because it has been determined that all modifications will be approved in the same manner as initial plan development. The fourth comment believes that ASCS has the authority to arbitrarily lessen or weaken program participation. The final rule has been clarified to eliminate this concern.

Section 703.17 Transfer of Land

Four comments were submitted recommending several changes for clarity. This section has been reorganized to clarify the manner in which the owner submitting a WRP contract will receive payment and how a new owner establishes eligibility for cost-share payments if the required practices were not completed by the previous owner.

Section 703.18 Monitoring and Enforcement of Easement Terms and Conditions

Eight comments were received. Three comments recommend that non-government organizations be delegated this responsibility. One comment volunteered their services in this endeavor. One comment was in opposition to any delegation of the monitoring or enforcement to other Federal or State agencies. Another comment believed ASCS should obtain written permission from the landowner in order to inspect the easement area. One comment recommends that management agreements may be entered into by the landowner and a third party at any time. Several comments indicated it is unreasonable

to expect a landowner to foresee all future management capabilities and needs at the time the easement is finalized. Allowing third party agreements at any time will increase the effectiveness of WRP by combining the efforts of Federal, state or private organizations having expertise for management and monitoring. Two comments stated that local groups may provide the most cost effective management and monitoring for this program. In many cases the partnership may be essential to enable landowner participation. The final rule has been amended to allow participants to enter into third party agreements for maintenance with private conservation organizations to ensure continued management of the easement area without the need for additional public funding.

Section 703.19 Violations

Six comments were received with a broad range of positions. One comment supported the position in the proposed rule. One comment recommended that graduated penalties be applied for program violations. One comment stated that the court system is too slow to enforce WRP easements. The fourth comment claimed it is not due process to require a refund from someone not receiving payment. Another comment stated that ASCS should not reimburse legal expenses. Finally, the sixth comment stated that the proposed provision was arbitrary and punitive. Based upon these comments, the provisions of this section have been amended to provide that any refund of WRP payments shall be made only by the person who received payment from ASCS. Since this program is designed to provide easements for the benefits of the United States, ASCS will avail itself of any and all remedies which it has, including the right to seek damages or equitable relief from Federal courts. Accordingly, no change in the provisions relating to use of the court system is made. There is no statutory basis to establish graduated penalties. Accordingly this suggestion has not been adopted.

Other Comments

Several comments suggested that landowners enrolling into the WRP should be exempt from property or real estate taxes after enrollment. Since ASCS is purchasing only a property right and is not obtaining ownership of the property, State tax liabilities remain with the landowner. Since this is a State law issue, ASCS does not have the authority to choose the manner in which

taxes are assessed on the WRP easement area. Accordingly, these suggested changes are not adopted.

Several comments also stated that ASCS should furnish the water necessary to ensure continuance of the restored wetland areas where water is currently being purchased or there is the potential for a lack of water to ensure continuance of the restored wetland area. This suggestion goes beyond the scope of the authorizing legislation. Accordingly, no change has been made in the regulation based on these comments.

Two comments encouraged the inclusion of a provision to allow subsequent cost-share assistance in the event of a natural disaster or similar event over which the producer had no control. The final rule at § 703.13(b) has been amended to authorize ASCS to provide cost-share assistance, at the discretion of ASCS, for the replacement or restoration of practices destroyed or lost due to reasons beyond the owner's control.

List of Subjects in 7 CFR Part 703

Administrative practices and procedures, Compliance procedures, Easements, Natural resources, Technical assistance and Wetlands Reserve Plan of Operations (WRPO).

Final Rule

Accordingly, title 7 of the Code of Federal Regulations, chapter VII is amended by adding a new part 703 to subchapter A to read as follows:

PART 703—WETLANDS RESERVE PROGRAM

- Sec.
- 703.1 Applicability.
 - 703.2 Administration.
 - 703.3 Definitions.
 - 703.4 Maximum county acreage.
 - 703.5 Maximum acreage limitation.
 - 703.6 Eligible person.
 - 703.7 Eligible land.
 - 703.8 Additional land eligibility provisions.
 - 703.9 Transfer of lands from the CRP to the WRP.
 - 703.10 Easement priority.
 - 703.11 Statement of intention to participate; submission of bids.
 - 703.12 Obligations of the landowner.
 - 703.13 Payments to landowners by ASCS.
 - 703.14 Payment limitation.
 - 703.15 Wetlands Reserve Plan of Operations.
 - 703.16 Easement modifications.
 - 703.17 Transfer of land.
 - 703.18 Monitoring and enforcement of easement terms and conditions.
 - 703.19 Violations.
 - 703.20 Performance based upon advice or action of the Department.
 - 703.21 Access to land under agreement.

- Sec.
- 703.22 Program payments and provisions relating to tenants and sharecroppers.
 - 703.23 Payments not subject to claims.
 - 703.24 Assignments.
 - 703.25 Appeals.
 - 703.26 Scheme and device.
 - 703.27 Filing of false claims.
 - 703.28 Miscellaneous.

Authority: 16 U.S.C. 3801 *et seq.*

§ 703.1 Applicability.

(a) The regulations in this part govern the Wetlands Reserve Program (WRP). With respect to fiscal year 1992 only, WRP shall be available to producers only in the following States: California, Iowa, Louisiana, Minnesota, Mississippi, Missouri, New York, North Carolina, and Wisconsin. These states have been determined to have the highest incidence of:

- (1) Significant acreage of hydric cropland;
- (2) Potential capacity of restoration;
- (3) Diversity in kinds of wetlands; or
- (4) Substantial benefits for migratory birds.

(b) Under the Wetlands Reserve Program, ASCS will accept voluntary offers for the purchase of easements from eligible persons who have eligible land with respect to which they agree to restore and protect farmed wetlands or converted wetlands and eligible adjacent lands. Such voluntary easements will be for the purpose of restoring the hydrology and vegetation, and protecting the functions and values of wetlands for wildlife habitat, water quality improvement, flood water retention, ground water recharge, open space, aesthetic values, environmental education, and other values determined appropriate by ASCS.

§ 703.2 Administration.

(a) The regulations in this part will be administered under the general supervision and direction of the Administrator, ASCS. In the field, the regulations in this part will be administered by the Agricultural Stabilization and Conservation State and county committees ("State committees" and "county committees", respectively).

(b) State executive directors, county executive directors and State and county committees do not have authority to modify or waive any of the provisions of this part.

(c) The State committee may take any action authorized or required by this part to be taken by the county committee which has not been taken by such county committee. The State committee may also:

- (1) Correct or require a county committee to correct any action taken

by such county committee which is not in accordance with this part; or

(2) Require a county committee to withhold taking any action which is not in accordance with this part.

(d) No delegation herein to a State or county committee shall preclude the Administrator of ASCS, or a designee, from determining any question arising under this part or from reversing or modifying any determination made by a State or county committee.

(e) Data furnished by the applicants will be used to determine eligibility for program benefits. Furnishing the data is voluntary; however, without it program benefits will not be provided.

(f)(1) The eligibility of the land for inclusion in the WRP will be based on the likelihood of successful wetland restoration and the merit of including the land in the program, taking into account the cost of the restoration.

(2) The development of the WRPO to achieve the desired objectives shall be made by the Soil Conservation Service (SCS) in agreement with the Fish and Wildlife Service (FWS), except that no determination by the SCS and the FWS shall compel ASCS to execute a contract or an easement which ASCS determines will serve the purposes of the program established by this part.

(3) The detailed designs to implement the practices and management measures in the WRPO shall be completed by the SCS, except that the Forest Service or State agency will assist with tree planting plans.

(4) ASCS shall consult with the SCS and FWS for such other technical assistance in the implementation of the WRP and may consult with State agencies and other groups and organizations for technical assistance in developing and implementing the WRPO.

(g) ASCS shall consult with the Forest Service (FS) or the State Forestry Agency for such assistance as is determined by SCS to be necessary for implementing WRPO's which include tree planting practices.

(h) ASCS may consult with the Extension Service (ES) to coordinate the related information and education program as deemed appropriate to implement the WRP.

§ 703.3 Definitions.

(a) The terms defined in part 719 of this chapter shall be applicable to this part and all documents issued in accordance with this part, except as otherwise provided in this section.

(b) The following definitions shall be applicable to this part:

Agricultural commodity means any crop planted and produced by annual tilling of the soil or on an annual basis by one trip planters or sugarcane planted or produced in a State or alfalfa and other multiyear grasses and legumes in rotation as approved by the Secretary. For purposes of determining crop history, as relevant to eligibility to enroll land in the program, land shall be considered planted to an agricultural commodity during a crop year if, as determined by ASCS, an action of the Secretary prevented land from being planted to the commodity during the crop year.

Annual payment means, unless the context indicates otherwise, the payment specified in the WRP agreement which is made annually to a participant to compensate such participant for placing eligible land in the WRP.

Applicant means a person who submits to ASCS an intention to participate in a WRP easement.

ASCS means the Agricultural Stabilization and Conservation Service.

Bid means, unless the context indicates otherwise, the total payment requested by the owner for granting an easement.

Conservation District (CD) means a subdivision of a State organized pursuant to an applicable State Conservation District Law or in instances where a conservation district does not exist, the State Conservationist of the Soil Conservation Service.

Contract means the document specifying the contracted obligations and rights of any person who is participating in the program.

Cost-share payment means the payment made by ASCS to assist program participants in establishing the practices required in a WRPO.

CRP means the Conservation Reserve Program provided for in 7 CFR parts 704 and 1410.

Deputy Administrator means the ASCS Deputy Administrator for State and County Operations (DASCO).

Easement means the real property interest acquired by ASCS under this part, and which is filed with the appropriate local or State government official.

Easement area means the land on which the approved restoration practices are required.

Easement farm means the area of land, including the easement area which has been conveyed by the most current deed recorded in the land records of the county where the easement area is located.

FWS means the Fish and Wildlife Service of the United States Department of the Interior.

Local ASCS office means the county office of the Agricultural Stabilization and Conservation Service serving the county or combination of counties in the area in which the landowner's farm or ranch is administratively located.

Non-permanent easement means an easement for the maximum duration permitted by State law or for 30 years.

Participant means a landowner who has an approved easement contract.

Permanent easement means an easement in perpetuity.

Practice means the wetland and easement area development restoration measures agreed to in the WRPO to accomplish the desired program objectives.

Riparian areas mean areas of land, which are directly influenced by free water in the soil, that occur along streams, channels, rivers, and other water bodies. They are normally distinctly different from the surrounding lands because of unique soil and vegetation characteristics. They may be identified by distinctive vegetative communities which are reflective of soil conditions normally wetter than adjacent soils.

SCS means the Soil Conservation Service of the United States Department of Agriculture.

Technical assistance means the assistance provided under the WRP to owners by a representative of the Department of Agriculture or the FWS in determining cropland eligibility, suitability for restoration, developing WRPO's, and implementing and certifying practices. State agencies, non-governmental organizations, and individuals, with the concurrence of the landowner, may provide technical assistance in the development of the WRPO.

WRP means the Wetlands Reserve Program provided for in this part.

WRPO means the Wetlands Reserve Plan of Operations provided for in this part.

§ 703.4 Maximum county acreage.

(a) Except for areas devoted to windbreaks or shelterbelts after November 28, 1990, the maximum acreage which may be placed in the ECARP may not exceed 25 percent of the total cropland in the county of which no more than 10 percent of the total cropland in the county may be subject to an easement.

(b) When statements of intention to participate in the WRP are received in counties that have exceeded the 25 percent limit, the county committee may

request a waiver for the purpose of enrolling such lands in the WRP. The limitation in paragraph (a) of this section shall not apply if ASCS determines that such action will not adversely affect the local economy of the county.

§ 703.5 Maximum acreage limitation.

ASCS will attempt to enroll no more than 1,000,000 acres in the WRP during the 1991-1995 calendar years and the cumulative total acreage enrolled will not exceed:

- (a) 200,000 acres through 1991;
- (b) 400,000 acres through 1992;
- (c) 600,000 acres through 1993;
- (d) 800,000 acres through 1994; and
- (e) 1,000,000 acres through 1995.

§ 703.6 Eligible person.

To be eligible to offer land for the WRP a person must be the owner of the eligible property for which enrollment is sought and must have been the owner of such land for at least the preceding 12 months prior to the end of the period in which the intent to participate is declared, as provided in this part, unless:

(a) It is determined by ASCS that the land was acquired by will or succession as a result of the death of the previous owner; or

(b) It is determined by ASCS that adequate assurances have been presented that the new owner of such land did not acquire such land for the purpose of placing it in the WRP.

§ 703.7 Eligible land.

(a)(1) Except as otherwise provided in this section, land may only be considered eligible for enrollment in the WRP if it is determined by SCS that the land:

(i) Is wetland farmed under natural conditions, a farmed wetland, or prior converted cropland which is cropland except that converted wetlands shall not be eligible for enrollment if the conversion was not commenced prior to December 23, 1985; and

(ii) Merits inclusion in the program based on the likelihood of successful restoration of the enrolled land and the resultant wetland values when considering restoration cost.

(2) Except in the case of land which qualifies as non-croplands under paragraph (b) of this section, land enrolled in the WRP must also:

(i) Have been annually planted or considered planted to an agricultural commodity in at least 1 of the 5 crop years 1986 through 1990;

(ii) Be suitable for planting to an agricultural commodity at the time of enrollment unless the land is wetlands

that have been restored on the land under a CRP contract, or under a Federal or State wetland restoration program without an easement of at least 30 years in which case the land need only to have been planted to an agricultural commodity 2 of the 5 crop years, 1981 through 1985; and

(iii) Not be a wetland mitigated under part 12 of this title.

(b) Non-cropland may qualify as eligible adjacent land if ASCS determines that including such land in the program would contribute significantly to the restoration of adjacent wetlands under paragraph (a) of this section;

(c) Determinations under this section will be made in accordance with the provisions of part 12 of this title, in such manner as may be prescribed by the Deputy Administrator.

(d) Eligible land also includes land which SCS determines to be:

(1) A riparian area along a stream or other waterway that links or after restoring the riparian area will link wetlands which are protected by an easement or other agreement that achieves the same objective as an easement;

(2) Land adjacent to the restored wetland, which would contribute significantly to the restoration of adjacent wetlands, but not more than an average of 100 feet wide, and not more than twice the area of the restored wetland as needed to protect the functions and values of wetlands restored under this part unless DASCO determines a larger area is necessary to meet the objectives of the WRP;

(3) Lands that otherwise meet the requirements of paragraph (a) of this section subject to an existing CRP contract, with the highest wetland functions and values, that are likely to return to production after the expiration of the CRP contract and adjacent lands that otherwise meet the requirements of paragraph (b) of this section; or

(4) Other wetlands of an owner that would not otherwise be eligible if the inclusion of such wetlands in the WRP easement would significantly add to the functions and values of the wetlands to be restored under this part.

(e) Notwithstanding any other provision of this section, land which meets the requirements of paragraphs (a) through (d) of this section, shall not be considered eligible land unless it is determined by the SCS in consultation with the FWS that:

(1) The wetland hydrology and vegetation can be restored to a condition approximating conditions which existed before conversion.

(2) Significant restoration and protection is probable, taking into consideration the cost of the restoration, for wetland functions and values of such land. Wetland functions and values shall include but are not limited to:

(i) The improvement of habitat for migratory birds and other wildlife;

(ii) The protection and improvement of water quality;

(iii) The attenuation of water flows due to flood;

(iv) The recharge of ground water;

(v) The protection and enhancement of open space and aesthetic quality; or

(vi) The educational and scientific values of the area.

(f) Eligible land must be configured in a manner which allows the owner to meet the objectives of the WRP.

§ 703.8 Additional land eligibility provisions.

Notwithstanding other provisions of this part, land that is eligible for enrollment in the WRP must not be:

(a) Converted wetlands if the conversion was commenced after December 23, 1985;

(b) Land that contains timber stands or trees established in connection with a CRP contract;

(c) Lands owned or acquired by an agency of the Federal Government; or

(d) Land subject to a deed restriction prohibiting the production of agricultural commodities or the alteration of existing wetland hydrology.

§ 703.9 Transfer of lands from the CRP to the WRP.

Land subject to an existing CRP contract may be offered for acceptance and transfer into the WRP only if:

(a) The land is eligible land for purposes of the WRP as provided in §§ 703.7 and 703.8 and

(b) The application for such transfer into the WRP is agreed to by ASCS. If such transfer is requested by the owner and agreed to by ASCS, the CRP contract for the property shall be terminated or otherwise modified subject to such terms and conditions as are mutually agreed. Transfers from CRP to WRP after the second available WRP signup period will only be permitted if the owner agrees to refund all payments received under the CRP since the close of the second available WRP signup period.

§ 703.10 Easement priority.

(a) In implementing the WRP, ASCS shall, to the extent practicable, in determining which WRP bids to accept, take into account the costs of obtaining an easement, future agricultural and food needs, and the benefits for

protecting and enhancing habitat for migratory birds and other wildlife that would be acquired through purchase of the easement.

(b) A formula will be used to ensure that offers will not be accepted in excess of the value of agricultural land, adjusted for: Soil productivity; nonland assets idled; landowner cost of wetland restoration; long term easement area operation and maintenance; long term costs for providing easement access route; and any other factors as may be allowed.

(c) In evaluating easement offers, different priorities for selection may be established by ASCS from time to time as determined by ASCS in order to accomplish the goals of the WRP.

(d) ASCS will rank the bids based on the environmental benefits per dollar of government expenditures on restoration and easement purchase. The factors for determining the priority for selection may include the following:

(1) Wetland hydrology restoration potential;

(2) Wetlands location significance including the contribution the restoration may make to the recovery of threatened and endangered species;

(3) Wetlands functions and values;

(4) Management risks;

(5) Duration of easements;

(6) Cost of restoration and easement purchase; and

(7) Any other factors as determined appropriate by ASCS.

§ 703.11 Statement of intention to participate; submission of bids.

(a) A person seeking to enroll land in the WRP must apply for enrollment by stating on an approved ASCS form their intention to participate in the WRP. The statement of intention must be filed with the local county ASC committee during an announced period for such submissions. Such periods may be announced periodically by ASCS.

(b) Following the statement of intention, the application will be considered complete only if such applicant:

(1) Obtains an approved WRPO; and

(2) Submits to ASCS a WRP bid setting out the total amount of easement payments that the person is willing to accept in return for participation in the program and for agreeing to other conditions for participation that may be required by ASCS, including the creation of an easement on the property. Such bids may be made no later than 90 days after the close of the period announced by ASCS for submitting a statement of intention to participate, unless a later date is agreed to by ASCS.

No bid may be accepted unless submitted on the approved ASCS form and unless it is determined that the land is eligible and that the submitter of the bid is an eligible person. The determination of which bids to accept shall be at the exclusive discretion of ASCS.

(c) A person submitting a statement of intention to participate shall not be obligated to submit a bid.

(d) A bid may be submitted only if signed by all owners of the property or their duly authorized representative.

§ 703.12 Obligations of the landowner.

(a) All owners of land for which a WRP bid is accepted by ASCS shall:

(1) Grant to ASCS an approved easement for the land which shall run with the land and shall be in favor of ASCS and its assigns or delegates which provides that the property shall be maintained in the manner specified by ASCS to ensure that the land is maintained in accordance with the goals and purposes of this part, including the maintenance of the restored wetland and eligible lands as specified in the WRPO for the full life of the easement. Such easement shall:

(i) Be a reserve interest easement that the Deputy Administrator determines is for a sufficient term of time necessary to achieve the purposes of the program. Permanent easements will be accepted and preferred whenever possible. However, the term of the easement shall be at least 30 years or the maximum extent allowed under State law;

(ii) Require that the maintenance of the land in accordance with the easement and with the terms of the WRPO shall be the responsibility of the owners of the property and their successors of any kind, including, but not limited to, the owner's heirs and assigns;

(iii) Grant to ASCS a right of access in favor of ASCS and its delegates, assigns and successors of any kind, to the portion of the property which is subject to the provisions of the WRPO. Maintenance of such access shall be the responsibility of the owner and their successors of any kind;

(iv) Reserve to ASCS the right to permit such compatible uses of the easement area as may be identified in the WRPO; and

(v) Reserve to the landowner those compatible uses identified in the WRPO that are permitted to be pursued by the landowner.

(2) Comply with all terms and conditions of the WRPO;

(3) Provide for creating and recording an appropriate deed restriction, as determined by ASCS, for such land as

necessary to meet the requirements of this subpart;

(4) Provide that the easement granted to ASCS is superior to the rights of all others, except as authorized by ASCS. Such action shall include, but not be limited to, providing a written statement of consent to such easement and disclaimer by those holding a security interest or any other encumbrance with respect to such and;

(5) Agree to the permanent retirement of the aggregate a total of crop acreage bases, and allotment and mandatory quota history on the farm or ranch to the extent that such crop acreage bases are not supported by the cropping pattern on the farm not including cropland enrolled in WRP;

(6) Not allow the grazing of the land or any other commercial use on the land, except as provided for in the WRPO, or harvesting of any agricultural commodity produced on the land subject to the WRP easement;

(7) Comply with Federal or State noxious weed laws in the manner specified in the WRPO;

(8) Control other identified weed and pest species, in the manner specified in the WRPO;

(9) Establish, maintain, and replace, as specified in the easement contract, the practices required in the WRPO as needed to meet the requirements of the WRPO, the easement contract, and the terms of the easement;

(10) Be responsible for repairs, improvements, and inspections of the WRPO practices as necessary to maintain existing public drainage systems when the land is restored to the condition required by the terms of the WRPO, the easement contract and the easement;

(11) Be permitted to control public access, in accordance with the WRPO, on the land enrolled in the program;

(12) Implement any additional provisions that are required by ASCS in consultation with SCS and FWS in the easement contract, WRPO, or easement, in order to, as determined by ASCS, facilitate the administration of the WRP;

(13) Not plant for harvest an agricultural commodity on the enrolled land for crop years subsequent to the acceptance of a WRP bid by ASCS;

(14) Not alter the vegetation, except to harvest already planted crops or forage, or hydrology on such offered acres subsequent to acceptance of a bid by ASCS except as provided for in the easement or WRPO;

(15) Be responsible for the long-term management of the easement in accordance with the terms of the easement and related agreements including the WRPO provided that

owners will have the option to enter into an agreement with governmental or private organizations to assist in the management of the easement area. No ASCS funds will be provided to the designated agencies or organizations for management expenses and the responsibility to ASCS for the management of the easement shall in all cases remain with the owner and the owner's successors of any kind regardless of whether such arrangements for third-party management are made with governmental or private organizations, including federal agencies;

(16) Agree that each person on the easement contract with ASCS, or who is subject to the easement, shall be jointly and severally responsible for compliance with the WRPO, the easement contract and the provisions of this subpart and for any refunds or payment adjustment which may be required for violation of any terms or conditions of the WRPO, the easement contract, or provisions of this subpart;

(17) Refrain from taking any action on the easement area unless specifically authorized in the reserve interest easement or the WRPO; and

(18) Secure any necessary local, State and Federal permits prior to commencing restoration of the designated area.

(b) In addition, program participants and their successors of any kind may:

(1) Not alter wildlife habitat and other natural land features of the enrolled land unless authorized by the WRPO;

(2) Apply pesticides or fertilizers on the enrolled land or mow such land, only as provided for in the WRPO; or

(3) Not engage in activities on other land on the person's farm area that will:

(i) Cause excessive sediment or other pollutants to enter the easement area;

(ii) Alter the flow of surface or subsurface water into or out of the easement area except as specified in the WRPO; or

(iii) Otherwise be inconsistent with the terms of the easement.

(c) The activities of any person on the property shall be considered for purposes of this section to be the actions of the program participant, except to the extent that ASCS determines that the activities of such other person were beyond the control of the owner, in which case ASCS may adjust the remedies that are otherwise provided for in this part to the extent determined consistent with program goals. Obligations created by the easement shall run with the land and shall bind all persons having an interest in the property at any time whether such

interest is created by death of the owner, sale, assignment, or otherwise.

§ 703.13 Payments to landowners by ASCS.

(a) ASCS will share the cost with landowners of rehabilitating the enrolled land in the WRP as provided in the WRPO, or the easement contract. The amount of the cost-share assistance shall be specified in the easement contract. Eligible costs for such cost-share assistance by ASCS shall only include those costs which ASCS determines are appropriate, and shall be subject to the following restrictions:

(1) ASCS shall pay:

(i) As determined by ASCS, not less than 75 percent of: the actual cost of establishing or installing the practices specified in the WRPO; or the average cost of establishing the practices specified in the WRPO for a permanent easement; and

(ii) Not less than 50 percent nor more than 75 percent, as determined by ASCS, of: the actual cost of establishing or installing the practices required by the WRPO; or the average cost of establishing the practices specified in the WRPO for other than a permanent easement.

(2) For purposes of determining average establishment or installation costs ASCS may take into account recommendations of the State and County Conservation Review Groups provided for in § 701.2(a) of this chapter and the determination of average costs shall be the average for the part of the county in which the land is located, except that if such an estimate is not possible, then an estimate for the whole county may be used, or if an estimate for part of the county or the whole county is not readily determinable, an estimate may be used for the State or part of the State in which the land is located;

(3) Cost-share payments may be made only upon a determination by ASCS that an eligible practice or an identifiable unit of the practice has been established in compliance with appropriate standards and specifications;

(4) Cost-share payments may be made only for the establishment or installation of an eligible practice and not for the maintenance of the practice except as specifically permitted in writing by the Deputy Administrator; and

(5) Cost-share payment determinations shall be made by the county committee but no easement contract may be approved which would allow for total WRP cost-shares in excess of 50 percent of the pre-easement fair market value of the property subject to the WRPO without written approval by the State committee or for more than

100 percent of such fair market value without the written approval of the Deputy Administrator.

(b) Notwithstanding paragraph (a)(4) of this section, cost share payments may be authorized for the replacement or restoration of practices for which cost share assistance has been previously allowed under the WRP, but only if:

(1) Replacement or restoration of the practice is needed to meet the objectives for which the easement was established; and

(2) The failure of the original practice was due to reasons beyond the control of the participant.

(c)(1) ASCS shall pay, at the times determined by ASCS, the agreed upon amount for the easement as determined through the acceptance of bids for eligible land through annual payments made in equal or unequal amount over a period not less than 5 years nor more than 20 years; except that in the case of permanent easements the easement payment may be made in a lump-sum amount.

(2) ASCS payments shall be made in cash;

(3) In the case of any non-permanent easement, the amount of payments that may be received per person, as determined under part 1497 (specifically § 1497.109(a)) of this title, shall be limited as provided for in this part;

(4) For all easements, ASCS shall withhold a portion of the payments that might otherwise be made pending completion of the restoration plan for the property and ASCS may condition any payment on satisfactory progress toward completion of the plan. At a minimum, ASCS shall pay no more than 10 percent per year of the total purchase price for the easement pending completion of the restoration of the wetlands;

(5) No payment may be made which would exceed the total amount bid and accepted for the property and payments may only be made if the person on whose account the payment is to be made:

(i) Has agreed to all terms and conditions of the program set out in this part;

(ii) Submitted an accepted bid on the standard ASCS-approved form for the WRP; and;

(iii) Is in full compliance with the terms and conditions of the WRP easement except to the extent that relief is authorized by this part and is approved under guidelines issued by the Deputy Administrator.

(d) ASCS will reimburse landowners offering an acceptable easement for fair and reasonable expense incurred for

title searches, filing expenses, and related costs, as determined by ASCS.

§ 703.14 Payment limitation.

With respect to non-permanent easements, the annual amount of payments paid to a person, as determined under part 1497 (specifically § 1497.109(a)) of this title, shall not exceed \$50,000.

§ 703.15 Wetlands reserve plan of operations.

(a) At the time of submitting a bid to enroll land in the WRP, the landowner must have obtained a WRPO for the land which has been approved by ASCS.

(b) The WRPO shall:

(1) Include an aerial photo displaying the land offered for enrollment;

(2) Specify the manner in which the farmed or converted wetlands included in the enrolled land shall be restored, operated, and maintained to accomplish the goal of the program together with other practices which may be necessary or appropriate to accomplish the goals of the program, including, where appropriate:

(i) Measures necessary to control noxious weeds and insect pests in order to comply with applicable Federal, or State noxious weed and pest control laws; and

(ii) Measures to the extent determined necessary in the WRPO to control other specified species of weeds, insects or pests.

(3) Specify compatible land uses for personal enjoyment or for which compensation may be received, if any, reserved to the landowner in the easement and the manner in which these uses are to be carried out, such uses may include among others:

(i) Recreational use, hunting and fishing;

(ii) Managed timber production including harvesting; and

(iii) Periodic haying or grazing consistent with the goals of the program.

(4) Set out cost estimates of the practices required by the WRPO;

(5) Identify access routes to be maintained for wetland restoration activities and future management and easement monitoring in connection with the land to be enrolled;

(6) Make provisions deemed necessary for maintaining public drainage system if present on lands subject to the WRPO;

(7) Contain scheduled implementation dates for restoration practices;

(8) In areas where natural runoff is no longer sufficient to support natural wetland vegetation, include appropriate

provisions, to ensure adequate hydrology; and

(9) Contain other provisions or limitations as ASCS, in consultation with the SCS and FWS, determines to be necessary.

(c) SCS and FWS will cooperate and may consult with any other agency or person as deemed necessary on the development of the WRPO with the landowner.

(d) The WRPO must be signed by SCS, FWS, CD, and the landowner before submission of a bid by an applicant. However, if agreement between SCS and FWS at the local level is not reached within 20 calendar days, the WRPO shall be developed by the State Conservationist of SCS in consultation with FWS.

(e) The WRPO may require that a temporary vegetative or water cover be established on the property if immediate establishment of a permanent cover is not practicable or otherwise desirable.

(f) The terms of an ASCS-approved WRPO shall not relieve the program participant of any obligation or term imposed or provided for in the easement contract, the easement, or this part.

(g) The WRPO, where appropriate, will provide for the development of a tree planting plan with the assistance of the Forest Service or State forestry agency.

(h) The WRPO, where appropriate will provide for the development by SCS of detailed plans for weed control, structural measures and their operation, vegetation establishment and management, and other measures as needed.

(i) Revisions of the WRPO to enhance or protect the value for which the easement was established may be made at any time at the request of and with the concurrence of the owner, SCS, FWS, and ASCS.

§ 703.16 Easement modifications.

After the easement has been recorded, no change will be made in the easement without a written request by the landowner and the written agreement of the Deputy Administrator, or a designee, who may grant such approval only where such approval is determined necessary or appropriate by the Deputy Administrator, or a designee, to achieve the goals of WRP or facilitate the practical administration and management of the easement area or the program, and will not adversely affect the functions and values for which the easement was established.

§ 703.17 Transfer of land.

(a) If a new owner purchases or obtains the right and interest in, or right

to occupancy of, the land subject to a WRP easement, such new owner shall be subject to the terms and conditions of the easement. The seller who is the signatory to the contract shall be entitled to receive all remaining WRP easement payments, if any. Eligible cost-share assistance shall be paid to the seller with respect to costs incurred by such seller.

(b) Upon the transfer of the property, any remaining cost-share payments shall be withheld and shall be paid only if the new owner or purchaser becomes a party to the easement contract within 60 days of the recordation of the deed transferring title to the new owner. Such payments shall be paid in the manner agreed to by the seller and the buyer. The new owner or purchaser shall be held responsible for assuring completion of all measures and practices required by the contract and the WRPO.

(c) Any transfer of the property prior to the filing of the easement shall void any intention to participate, bid, or WRP easement contract unless the new owner agrees to be a party to the intention to participate, bid, or contract within 60 days of the recordation of the deed transferring the land to the new owner.

§ 703.18 Monitoring and enforcement of easement terms and conditions.

(a) ASCS or its representative shall be permitted to inspect each easement area at any and all times determined necessary or appropriate by ASCS to ensure that:

(1) Structural and vegetative restoration work are properly maintained;

(2) The wetlands and adjacent upland habitat of the easement area is being managed as required in the WRPO, and the terms of the easement; and

(3) Uses of the area are consistent with the terms and conditions of the easement contract, the WRPO and any related agreement.

(b) If an owner or other interested party is unwilling to voluntarily correct, in a timely manner, deficiencies in compliance with the terms of the WRPO, the WRP easement, or any related agreements, ASCS may at the expense of any person who is subject to the WRP easement correct such deficiency. Such ASCS action shall be in addition to other remedies available to ASCS.

(c) Management, monitoring and enforcement responsibilities may be delegated by ASCS at any time to other Federal or State agencies or, for management responsibilities only, private conservation organizations that have the appropriate authority, expertise, and resources necessary to

carry out such delegated responsibilities, as determined by ASCS.

§ 703.19 Violations.

(a) If a violation of the terms and conditions of the easement contract, the WRPO or the recorded WRP easement occurs, the easement shall remain in force and ASCS may, in addition to taking action as provided in § 703.26:

(1) Require the owner to fully restore the easement area, to fulfill the terms and conditions of the easement and WRPO; and

(2) Require the owner, who received payments from ASCS to refund all or part of such payments received together with interest as determined appropriate by ASCS.

(b) If an owner fails to carry out the terms and conditions of an easement, appropriate legal action may be initiated under civil law, or such other authority available to the entity assigned management responsibilities to compel such compliance may be used. The owner of the property shall reimburse ASCS for all costs incurred including but not limited to legal fees.

§ 703.20 Performance based upon advice or action of the Department.

The provisions of part 790 of this chapter relating to performance based upon the action or advice of a representative of the Department shall be applicable to this part.

§ 703.21 Access to land under agreement.

In order to determine eligibility and compliance with respect to this part, representatives of the Department, or designee thereof, shall have the right of access to:

(a) Land which is the subject of an application made in accordance with this part,

(b) Land which is subject to an easement made in accordance with this part, and

(c) Records of the producer which release such land.

§ 703.22 Program payments and provisions relating to tenants and sharecroppers.

(a) Payments received under this part shall be divided in the manner specified in the applicable easement contract.

(b) ASCS shall ensure that producers who would have shared in the risk of producing crops on land subject to such easement receive treatment deemed to be equitable in accordance with § 1413.150 of this title.

§ 703.23 Payments not subject to claims.

Subject to parts 3 and 1403 of this title, any cost-share or easement

payment or portion thereof due any person under this part shall be allowed without regard to any claim or lien in favor of any creditor, except agencies of the U.S. Government.

§ 703.24 Assignments.

Any participant who may be entitled to any cash payment under this program may assign the right to receive such cash payments, in whole or in part, as provided in part 1404 of this title.

§ 703.25 Appeals.

(a) Except as provided in paragraph (b) of this section, a participant in the WRP may obtain a review of any administrative determination rendered under the program in accordance with the administrative appeal regulations provided in part 780 of this chapter.

(b) Determinations concerning land eligibility, development of WRPO's or determining the potential for restoration of an offered area may be reviewed in accordance with procedures established under part 614 of this title or as otherwise established by SCS.

§ 703.26 Scheme and device.

(a) If it is determined by ASCS that a landowner has employed a scheme or device to defeat the purposes of this part, any part of any program payment otherwise due or paid such landowner during the applicable period may be withheld or be required to be refunded

with interest thereon, as determined appropriate by ASCS, and the contract with the landowner may be terminated. In such a case, ASCS may also continue to hold the easement interest acquired under this part.

(b) A scheme or device includes, but is not limited to, coercion, fraud, misrepresentation, depriving any other person of cost-share assistance or land payments for easements, and obtaining a payment that otherwise would not be payable.

(c) An owner of land subject to this part who succeeds to the responsibilities under this part shall report in writing to ASCS any interest of any kind in the land subject to this part that is retained by a previous participant. Such interest shall include a present, future or conditional interest, reversionary interest or any option, future or present, with respect to such land and any interest of any lender in such land where the lender has, will, or can obtain, a right of occupancy to such land or an interest in the equity in such land other than an interest in the appreciation in the value of such land occurring after the loan was made. A failure of full disclosure will be considered a scheme or device under this section.

§ 703.27 Filing of false claims.

If it is determined by ASCS that any participant has knowingly supplied false

information or has knowingly filed a false claim, such participant shall be ineligible for payments under this part. False information or false claims include claims for payment for practices which do not meet the specifications of the applicable WRPO. Any amounts paid under these circumstances shall be refunded, together with interest as determined by ASCS, and any amounts otherwise due such participant shall be withheld.

§ 703.28 Miscellaneous.

(a) Except as otherwise provided in this part in the case of death, incompetency, or disappearance of any landowner, any payment due under this part shall be paid to the landowner's successor in accordance with the provisions of part 707 of this chapter.

(b) The provisions of 7 CFR part 791 are applicable to this part.

(c) Any remedies permitted ASCS under this part shall be in addition to any other remedy, including, but not limited to criminal remedies, or actions for damages in favor of ASCS as may be permitted by law.

Signed this May 21, 1992 in Washington, DC.

Keith D. Bjerke,

Administrator, Agricultural Stabilization and Conservation Service.

[FR Doc. 92-13044 Filed 6-1-92; 1:29 pm]

BILLING CODE 3410-05-M

federal register

**Thursday
June 4, 1992**

Part IV

Department of Transportation

Federal Aviation Administration

**14 CFR Part 121, et al.
Special Federal Aviation Regulation No. 38;
Certification and Operating Requirements;
Rule**

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Parts 121, 125, 127, 129, and 135

[Docket No. 18510; SFAR No. 38-8]

Special Federal Aviation Regulation No. 38; Certification and Operating Requirements

AGENCY: Federal Aviation Administration [FAA], DOT.

ACTION: Final rule; request for comments.

SUMMARY: This amendment establishes a new termination date for Special Federal Aviation Regulation [SFAR] No. 38-2 [50 FR 23941; June 7, 1985], which contains the certification and operating requirements for persons conducting commercial passenger or cargo operations. The FAA stated in previous extensions of SFAR 38-2 that it was necessary to establish a new termination date for SFAR 38-2 to allow time for the FAA to complete the rulemaking process that will consolidate the rules regarding certification and operating requirements and incorporate SFAR 38-2 into the Federal Aviation Regulations (FAR). The current termination date for SFAR 38-2 is June 1, 1992. Because the FAA has not completed that rulemaking process, a 1-year extension of the termination date is necessary. SFAR 38-2 is extended to ensure that the FAA has adequate time to complete the consolidation of the rules regarding certification and operating requirements. However, if a final rule, which consolidates those rules, is issued before the new termination date, the FAA intends to publish a notice rescinding SFAR 38-2 concurrently with the publication of the final rule in the Federal Register.

DATES: Effective date June 1, 1992. Comments must be received on or before August 3, 1992.

ADDRESSES: Send comments on the rule in triplicate to: Federal Aviation Administration, Office of the Chief Counsel, Attn: Rules Docket (AGC-10), Docket No. 18518, 800 Independence Avenue, SW., Washington, DC 20591, or deliver comments in triplicate to: Federal Aviation Administration, Rules Docket, room 916, 800 Independence Avenue, SW., Washington, DC. Comments may be examined in the Rules Dockets weekdays, except Federal holidays, between 8:30 a.m. and 5 p.m.

FOR FURTHER INFORMATION CONTACT: Ms. Donell Pollard, Project Development

Branch, AFS-240, Air Transportation Division, Flight Standards Service, Federal Aviation Administration, 800 Independence Avenue SW., Washington, DC 20591; Telephone (202) 267-3750.

SUPPLEMENTAL INFORMATION:

Background

On December 12, 1978, the FAA issued SFAR 38 (43 FR 58366; December 14, 1978) as a consequence of the Airline Deregulation Act of 1978 (ADA or Act) (Pub. L. 95-504, 92 Stat. 1705). That Act expresses the Congressional intent that the Federal Government diminish its involvement in regulating the economic aspects of the airline industry. To accomplish this, Congress directed that the Civil Aeronautics Board (CAB) be abolished on December 31, 1984, and that certain of its functions cease before that date. Anticipating its sunset, the CAB itself curtailed or suspended much of its regulatory activity during the period 1979-1984. By January 1, 1985, the remaining CAB functions were transferred to the Department of Transportation (DOT).

Because some aspects of FAA safety regulations relied upon CAB definitions and authority, the FAA found it necessary in 1978 to adopt an interim measure to provide for an orderly transition to the change in economic regulatory activities. This action was consistent with the Congressional directive contained in section 107(a) of the Act that the deregulation of airline economics result in no diminution of the high standard of safety in air transportation that existed when the ADA was enacted. SFAR 38 (43 FR 58366; December 14, 1978) set forth FAA certification and operating requirements applicable to all "air commerce" and "air transportation" operations for "compensation or hire." (SFAR 38 did not address part 133 External Load Operations, Part 137 Agriculture Aircraft Operations, or part 91 training and other special purpose operations.)

On December 27, 1984, the FAA issued SFAR 38-1 (50 FR 450; January 4, 1985), which merely extended the termination date of SFAR 38 and allowed the FAA time to propose and receive comments on revising SFAR 38.

On May 28, 1985, the FAA issued SFAR 38-2 (50 FR 23941; June 7, 1985), which updated SFAR 38 in light of changes since 1978 and clarified provisions stating which FAA regulations apply to each air carrier and each type of operation. This action was necessary because of the changes in the air transportation industry brought about by economic deregulation. Before

deregulation, economic certificates were rigidly compartmentalized, and each air carrier typically was authorized to conduct only one type of operation (domestic, flag, or charter (i.e., supplemental)). The safety certificate issued to the air carrier by the FAA paralleled the authorization granted in the air carrier's economic certificate. Economic deregulation broke down the barriers between the various types of operations. The economic authority granted an air carrier by the DOT is no longer indicative of the safety regulations applicable to the type of operation authorized by the FAA. Thus, it was necessary for the FAA to establish guidelines to determine what safety standards were applicable to an air carrier's particular operation.

On April 30, 1986, the FAA issued SFAR 38-3 (51 FR 17274; May 9, 1986), which extended the termination date of SFAR 38-2 to allow the FAA time to incorporate its contents into Notice No. 88-16 (53 FR 39852; October 12, 1988). That notice proposes to consolidate the certification and operating requirements rules in parts 121 and 135, and to incorporate various provisions of SFAR 38-2 into new part 119 of the FAR.

On July 15, 1987, the FAA issued SFAR 38-4 (52 FR 28938; August 4, 1987), which reinstated SFAR 38-2, because it was inadvertently allowed to expire, and extended its termination date to June 1, 1989. That extension allowed the FAA time to incorporate the contents of SFAR 38-2 into Notice No. 88-16.

On May 26, 1989, the FAA issued SFAR 38-5 (54 FR 23884; June 2, 1989), which extended the expiration date of SFAR 38-2 to June 1, 1990, in order for the FAA to consider comments on Notice No. 88-16 and to issue a final rule which would consolidate the certification and operating requirements rules of SFAR 38-2, part 121, and part 135.

On April 11, 1990, the FAA reopened the comment period for Notice No. 88-16 (55 FR 14404; April 17, 1990) for comments on the definition of "scheduled operation" and the notification requirement for changes to operations specifications for a period of 30 days. The reopened comment period closed May 17, 1990.

To allow for additional time to consider comments received during the reopened comment period, the FAA extended the expiration date for SFAR 38-2 until June 1, 1991 (55 FR 23046; June 5, 1990). Because of the complexity of the comments, the expiration date for SFAR 38-2 again was extended until June 1, 1992 (56 FR 25450; June 4, 1991).

Based on comments received, the FAA has determined that a different definition of "scheduled operation" should be proposed for public comment. Therefore, in order to allow time to issue the supplemental notice of proposed rulemaking, consider comments, and issue a final rule, it is necessary to extend the expiration date for SFAR 38-2 until June 1, 1993.

Good Cause Justification for Immediate Adoption

The reasons which justify the adoption, and the subsequent revision, of SFAR 38 still exist. Therefore, it is in the public interest to establish a new termination date for SFAR 38-2 of June 1, 1993. If the FAA publishes a final rule incorporating SFAR 38-2 into the FAR before the termination date, a notice rescinding SFAR 38-2 will be published concurrently. This action is necessary to permit continued operations under SFAR 38, as amended, and to avoid confusion in the administration of FAA regulations regarding operating certificates and operating requirements.

For this reason, and because this amendment continues in effect the provisions of a currently effective SFAR and imposes no additional burden on any person, I find that notice and public procedures are unnecessary, impracticable, and contrary to the public interest, and that the amendment should be made effective in less than 30 days after publication. However, interested persons are invited to submit such comments as they desire regarding this amendment. Communications should identify the docket number and be submitted in duplicate to the address above. All communications received on or before the close of the comment period will be considered by the Administrator, and this amendment may be changed in light of the comments received. All comments will be available, both before and after the closing date for comments, in the Rules Docket for examination by interested parties.

Regulatory Flexibility Determination

The Regulatory Flexibility Act of 1980 (RFA) was enacted to ensure that small

entities are not unnecessarily and disproportionately burdened by Government regulations. The RFA requires agencies to review rules which may have "a significant economic impact on a substantial number of small entities."

This rule will not impose any additional incremental costs over those that would have been incurred when SFAR 38-2 was first issued. Therefore, I certify that the amendment will not have a significant economic impact on a substantial number of small entities.

International Trade Impact Analysis

The FAA finds this amendment will have no impact on international trade.

Federalism Implications

The amendment herein would not have substantial direct effects on the states, on the relationship between the national government and the states, or on the distribution of power and responsibilities among the various levels of government. Therefore, in accordance with Executive Order 12612, it is determined that this amendment would not have sufficient federalism applications to warrant the preparation of Federalism Assessment.

Conclusion

The FAA has determined that this document involves an amendment that imposes no additional burden on any person. Accordingly, it has been determined that: The action does not involve a major rule under Executive Order 12291; it is not significant under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979); and the anticipated impact is so minimal that a full regulatory evaluation is not required.

List of Subjects

14 CFR Part 121

Air carrier, Aircraft, Airmen, Air transportation, Aviation safety.

14 CFR Part 125

Aircraft, Airmen, Airports, Airspace, Air traffic control, Air transportation, Chemicals, Children, Drugs, Flammable

materials, Handicapped, Hazardous materials, Infants, Smoking.

14 CFR Part 127

Air carriers, Aircraft, Airmen, Airworthiness.

14 CFR Part 129

Air carriers, Aircraft, Airmen, Air transportation, Aviation safety, Safety.

14 CFR Part 135

Air carriers, Aircraft, Airmen, Air taxis, Air transportation, Airworthiness, Aviation safety, Safety.

Adoption of the Amendment

In consideration of the foregoing SFAR 38-2 (14 CFR parts 121, 125, 127, 129, and 135) of the Federal Aviation Regulations is amended as follows:

1. The authority citation for part 121 continues to read as follows:

Authority: 49 U.S.C. app. 1354(a), 1355, 1356, 1357, 1401, 1421-1430, 1472, 1485, and 1502; 49 U.S.C. 106(g).

2. The authority citation for part 125 continues to read as follows:

Authority: 49 U.S.C. 1354, 1421 through 1430, and 1502; 49 U.S.C. 106(g) (revised Pub. L. 97-449, January 12, 1983).

3. The authority citation for part 127 continues to read as follows:

Authority: 49 U.S.C. app. 1354(a), 1421, 1422, 1423, 1424, 1425, 1430; 49 U.S.C. 106(g).

4. The authority citation for part 129 continues to read as follows:

Authority: 49 U.S.C. app. 1346, 1354(a), 1356, 1357, 1421, 1502, 1511; 49 U.S.C. 106(g); Sec. 101 et seq., Pub. L. 101-604, 104 Stat. 3066.

5. The authority citation for part 135 continues to read as follows:

Authority: 49 U.S.C. app. 1354(a), 1355(a), 1421 through 1431, and 1502; 49 U.S.C. 106(g).

Special Federal Aviation Regulation No. 38-2 is amended by removing the words "June 1, 1992" in the last paragraph, and by adding in their place the words "June 1, 1993."

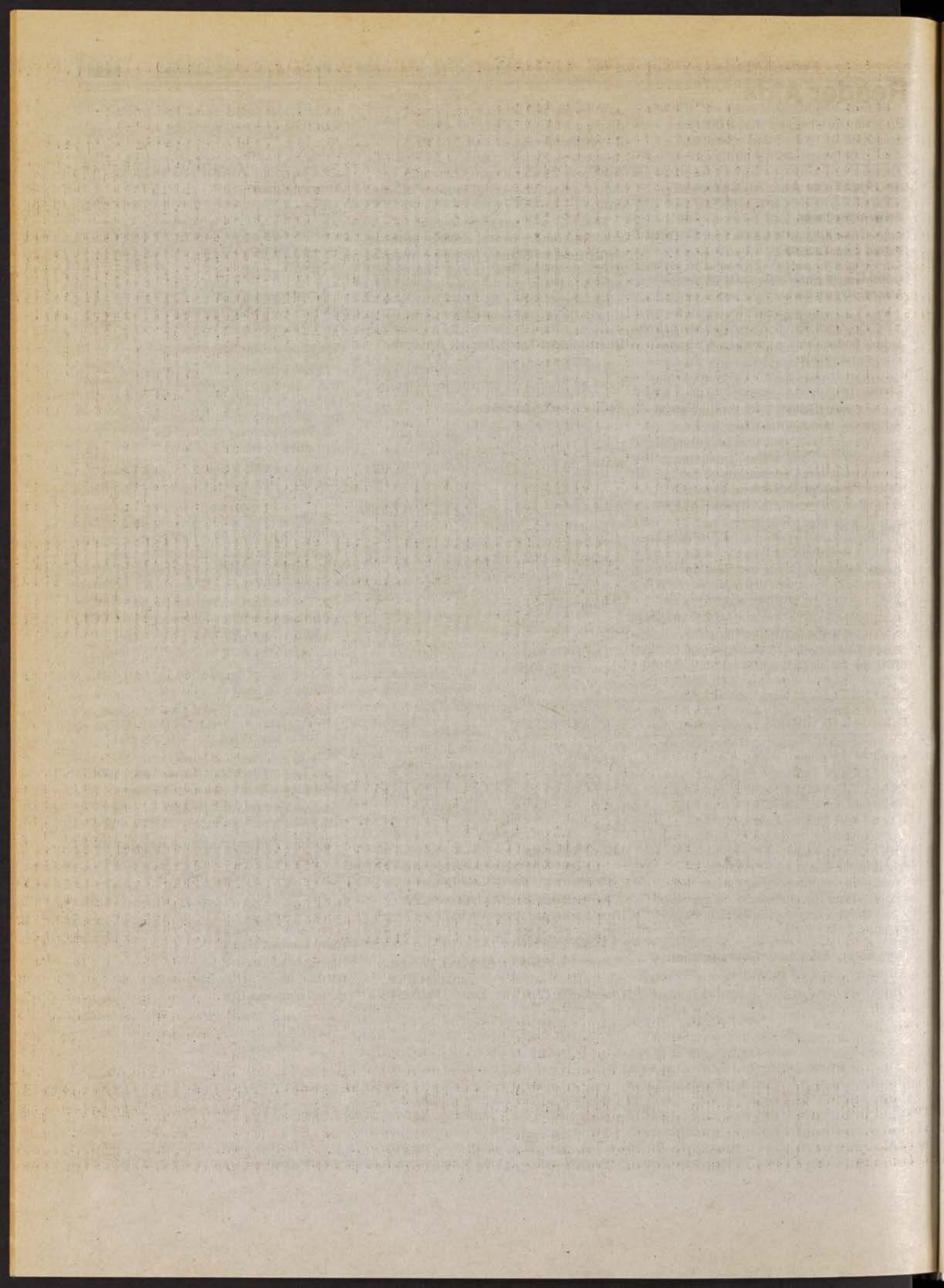
Issued in Washington, DC, on June 1, 1992.

Barry Lambert Harris,

Acting Administrator.

[FR Doc. 92-13054 Filed 6-1-92; 3:47 pm]

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Reader Aids

Federal Register

Vol. 57, No. 108

Thursday, June 4, 1992

INFORMATION AND ASSISTANCE

Federal Register

Index, finding aids & general information	202-523-5227
Public inspection desk	523-5215
Corrections to published documents	523-5237
Document drafting information	523-5237
Machine readable documents	523-3447

Code of Federal Regulations

Index, finding aids & general information	523-5227
Printing schedules	523-3419

Laws

Public Laws Update Service (numbers, dates, etc.)	523-6641
Additional information	523-5230

Presidential Documents

Executive orders and proclamations	523-5230
Public Papers of the Presidents	523-5230
Weekly Compilation of Presidential Documents	523-5230

The United States Government Manual

General information	523-5230
---------------------	----------

Other Services

Data base and machine readable specifications	523-3447
Guide to Record Retention Requirements	523-3187
Legal staff	523-4534
Privacy Act Compilation	523-3187
Public Laws Update Service (PLUS)	523-6641
TDD for the hearing impaired	523-5229

CFR PARTS AFFECTED DURING JUNE

At the end of each month, the Office of the Federal Register publishes separately a List of CFR Sections Affected (LSA), which lists parts and sections affected by documents published since the revision date of each title.

3 CFR

Executive Orders:	
12324 (Revoked by EO 12807)	23133
12807	23133
12808	23299

Proclamations:

4865 (See EO 12807)	23133
---------------------	-------

5 CFR

430	23043
432	23043
540	23043

Proposed Rules:

890	23126
-----	-------

7 CFR

703	23908
-----	-------

9 CFR

91	23046
93	23048

Proposed Rules:

91	23066
160	23540
161	23540
162	23540

10 CFR

595	23523
-----	-------

Proposed Rules:

100	23548
-----	-------

12 CFR

Proposed Rules:

611	23348
615	23348
627	23348

14 CFR

21	23523
29	23523
39	23049-23053, 23126, 23135, 23526-23530
121	23922
125	23922
127	23922
129	23922
135	23922
139	23126

Proposed Rules:

Ch. I	23165
21	23165
23	23165
39	23168, 23169, 23549-23553
71	23126, 23257
382	23555

15 CFR

Proposed Rules:

Ch. IX	23067
--------	-------

17 CFR

1	23136
3	23136

18 CFR

1301	23531
------	-------

Proposed Rules:

33	23171
35	23171
290	23171

20 CFR

404	23054, 23155
416	23054

21 CFR

558	23058
807	23059
1308	23301

Proposed Rules:

146	23555
334	23174

23 CFR

Proposed Rules:

Ch. I	23460
-------	-------

26 CFR

Proposed Rules:

1	23176, 23356
301	23356

27 CFR

Proposed Rules:

9	23559
24	23357

28 CFR

541	23260
-----	-------

29 CFR

1910	23060
------	-------

30 CFR

Proposed Rules:

202	23068
935	23176-23179
944	23181

32 CFR

355	23157
706	23061

33 CFR

100	23302, 23303, 23533, 23534
165	23304, 23534

FEDERAL REGISTER PAGES AND DATES, JUNE

23043-23134	1
23135-23300	2
23301-23522	3
23523-23924	4

Proposed Rules:

100.....	23458
110.....	23458
117.....	23363
165.....	23364, 23458, 23561

37 CFR**Proposed Rules:**

1.....	23257
2.....	23257

39 CFR**Proposed Rules:**

111.....	23072
----------	-------

40 CFR

61.....	23305
261.....	23062
271.....	23063

Proposed Rules:

180.....	23366
185.....	23366
721.....	23182
763.....	23183

41 CFR**Proposed Rules:**

105.....	23368
106.....	23368
107.....	23368

42 CFR**Proposed Rules:**

412.....	23618
413.....	23618

44 CFR

64.....	23159
---------	-------

46 CFR

221.....	23470
----------	-------

Proposed Rules:

510.....	23563
520.....	23564
550.....	23564, 23566
580.....	23368, 23563, 23564, 23566
582.....	23563

47 CFR

1.....	23160, 23161
73.....	23162

Proposed Rules:

73.....	23188, 23567
---------	--------------

48 CFR

552.....	23163
710.....	23320
752.....	23320

Proposed Rules:

9903.....	23189
9905.....	23189

49 CFR

544.....	23535
1332.....	23538

Proposed Rules:

Ch. VI.....	23460
391.....	23370
1004.....	23072
1023.....	23372
1321.....	23568

50 CFR

227.....	23458
----------	-------

663.....	23065
672.....	23163, 23321-23346
675.....	23321, 23347

Proposed Rules:

653.....	23199
----------	-------

LIST OF PUBLIC LAWS

Note: No public bills which have become law were received by the Office of the Federal Register for inclusion in today's List of Public Laws.

Last List June 2, 1992

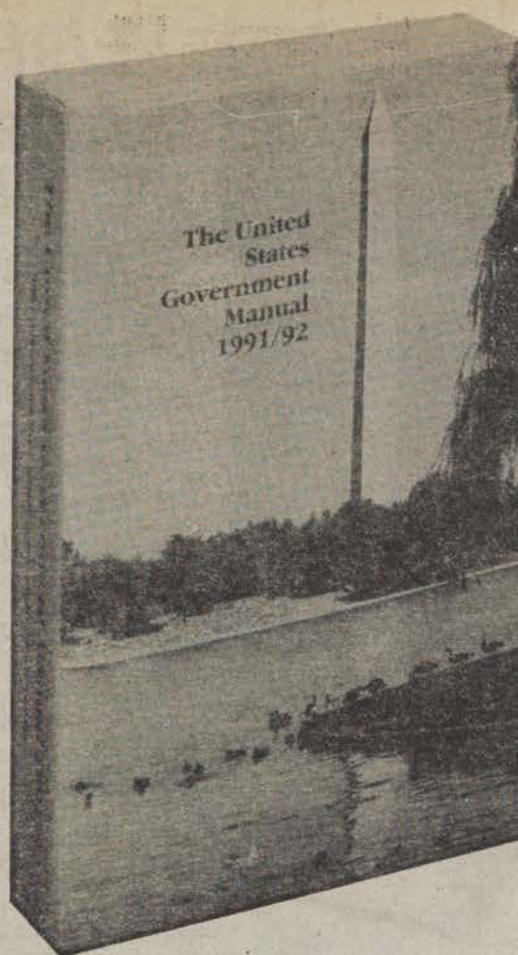
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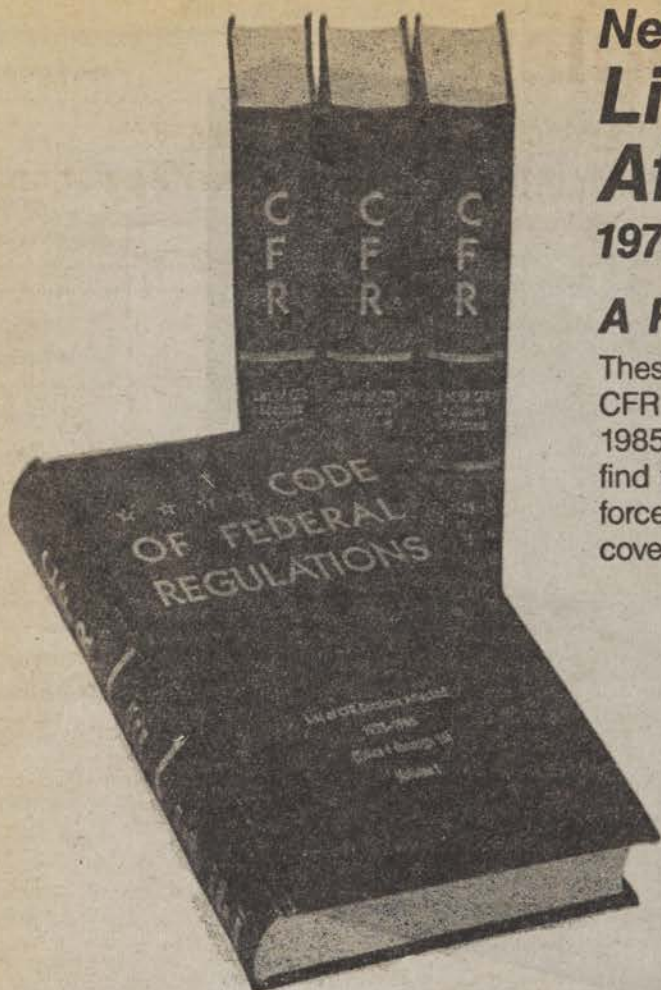
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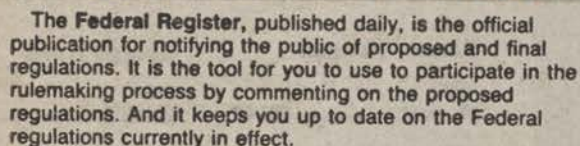
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